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MISSISSIPPI REVISITED: POVERTY AND HUNGER PROBLEMS AND PROSPECTS

HEARING

BEFORE THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

HEARING HELD IN BOLTON, MS, MAY 3, 1991

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CONTENTS

Page

Hearing held in Bolton, MS, May 3, 1991 ... 1

Statement of:

- Barber, Rims, Executive Director, Human Services Coalition ... 6
- Branch, Beatrice J., Executive Director, Mississippi Department of Human Services ... 29
- Butler, Hon. Lawrence, Mayor, Bolton, Mississippi ... 2
- Hinton, Agnes, Director, Nutrition Services, Mississippi State Department of Health ... 15
- Hudson, Viola, Volunteer Nutrition Educator, Partners in Nutrition and Health [PINAH] ... 22
- Johnson, Wesley, Superintendent of Hinds County Public Schools ... 1
- Marshall, Billie J., Director, Council on Aging, Mississippi Department of Human Services ... 18
- Moore, Carolyn, Participant, Self-Employment Initiative Demostration Project (SEID) ... 32
- Shirley, Aaron, M.D., Jackson-Hinds Health Center ... 20

Prepared statements, letters, supplemental material, et cetera:

- Branch, Mrs. Beatrice J., Executive Director, Mississippi Department of Human Services, Testimony ... 104
- Emerson, Hon. Bill, a Representative in Congress from the State of Missouri, Remarks ... 45
- Espy, Hon. Mike, a Representative in Congress from the State of Mississippi, Opening statement ... 39
- Hall, Hon. Tony P., a Representative in Congress from the State of Ohio, Opening statement ... 38
- Higher Prices, Fewer Choices: Shopping for Food in Rural America, Supplemental material ... 73
- Hinton, Agnes W., Director, Nutrition Services, Mississippi State Department of Health, Questions and Answers ... 49
  - Statement to the Select Committee on Hunger Hearing ... 52
- Home Visits and Lunch—Senior Nutrition Center ... 126
- Hudson, Viola, EFNEP Educator, Mississippi Cooperative Extension Service, Letter ... 37
  - Submissions to the Select Committee on Hunger ... 122
  - Testimony for the Select Committee on Hunger ... 59
- Marshall, Billie J., Director, Council on Aging, Mississippi Department of Human Services, Jackson, MS, Written comments submitted ... 94
- Mississippi Human Services Coalition, Letter ... 57
- Mississippi Nutrition Surveillance System 1988 Report, Bureau of Health Services, Terry Beck, Chief Nutrition Services ... 83
- Mississippi Revisited: Poverty and Hunger—Problems and Prospects, Fact Sheet ... 64
- Mississippi Surveillance of Severe Pediatric Undernutrition Project 1988-1990, Supplemental material ... 86
- Moore, Carolyn, Private Citizen, Statement ... 62
- Outstanding Training Program Self-Employment Initiative Demonstration Program, Jackson, Mississippi, Supplemental material ... 124
- Partners For Improved Nutrition and Health ... 80
- Self-Employment Initiative Demonstration Project, Canton, Mississippi, Supplemental material ... 123
- Shirley, Aaron, M.D., Malnutrition, Consequences and Possible Solutions ... 110
- State Profiles for Mississippi, Supplemental material ... 90

MISSISSIPPI REVISITED: POVERTY AND HUNGER PROBLEMS AND PROSPECTS

FRIDAY, MAY 3, 1991

House of Representatives,
Select Committee on Hunger,
Bolton, MS

The Select Committee met, pursuant to notice, at 1:31 p.m., in the Attendance Center, Bolton, Mississippi, Hon. Tony P. Hall presiding.

Members present: Representatives Hall, Engel, Espy, and Emerson.

The Chairman. Good afternoon. My name is Tony Hall and I am a Member of Congress from Ohio. My district is Dayton, Ohio, and the surrounding suburbs. I am very pleased to be here with your Congressman Mike Espy, Congressman Bill Emerson from Missouri, and Congressman Eliot Engel from New York City.

Before we get started, I just want to say on behalf of all of us that we are very enthused and excited about the tremendous welcome that we have had, not only since last night but as we walked into this gym, the preparation that it took to make all of this happen.

I especially want to thank the superintendent, Wesley Johnson, principal Joseph Brown, and all of the students and teachers who painted and finished this floor up here and built this platform and all of the things that have made this place just sparkle. We just want to thank you. You have made us feel very good, and it is a pleasure to be here.

Before we begin the hearing, the Honorable Lawrence Butler, the Mayor of Bolton, and Dr. Wesley Johnson, the superintendent of the Hinds County public schools, would like to welcome the committee to Bolton.

STATEMENT OF WESLEY JOHNSON, SUPERINTENDENT OF HINDS COUNTY PUBLIC SCHOOLS

Mr. Johnson. The Honorable Mike Espy, Honorable Hall, Emerson, Engel, and the Honorable Ray Mableson are absent. We are highly honored and highly esteemed to have you here at Bolton to conduct this hearing on one of the most basic problems in our society, and that is hunger.

On behalf of the Hinds County School District, we welcome you and we extend to you a heartfelt thanks for choosing our school and our community for this most important hearing.

To your staff and to you, gentlemen, please be assured that if there is any way we can do anything to provide further assistance for these proceedings, be assured that you do not have to hesitate to call on us.

May I say, gentlemen, that this hearing is most significant to me because at the beginning of this particular school year over 3,600,000 youngsters entered America's public schools. Of that number, 25 percent live in poverty. For Blacks, it was 50 percent; for Hispanics, 40 percent. So as you can see, we do have a problem. For Mississippi there are 36 percent of our people living below the poverty line, and the relationship between poverty and the incidence of hunger is well documented.

So again, let me thank you and welcome you. If there is any way that we can be of further assistance to you, please do not hesitate to call on us.

The CHAIRMAN. Thank you, Mr. Johnson.

STATEMENT OF HON. LAWRENCE BUTLER, MAYOR, BOLTON, MISSISSIPPI

Mr. BUTLER. Looking around at the young kids in the auditorium, in my wildest dreams, when I was a young boy that age, that I would ever think that I would have the opportunity that I have today. But I am deeply honored that I have this opportunity.

To Congressman Hall, the chairman of this group, Emerson and Engel, I am sure I speak for the Town of Bolton and all its citizens when I say how honored we are today to have you here.

Now, Congressman Espy does not need an invitation because he has a standing invitation any time in Bolton. Thank you for coming.

The CHAIRMAN. We thank you, Mayor, very much. [Applause.] We all want to thank all of you for coming out to join us this afternoon.

The committee is here today at the request of the chairman of our Task Force on Domestic Hunger, your congressman, Mike Espy. We are all honored to be here and we are thankful to Mike for giving us this opportunity to examine how federal assistance programs are doing in the fight to end hunger and poverty here in the Delta.

If you know Mike Espy, you know how committed and persistent he is. The fact that he has brought us to Bolton today shows how concerned he is about what is happening here. Mike wants to educate the committee and his other colleagues in the Congress about what steps we need to take to wipe out poverty and hunger in this Delta.

When the committee was last in Mississippi in 1987, over 25 percent of the population lived in poverty, the unemployment rate stood at 11.7 percent, and 14 out of every thousand babies born died before their first birthday. These statistics were all higher than the national figures. Since then, the Congress approved the Family Support Act of 1988 to provide new opportunities for job training and employment. We passed the Hunger Prevention Act of 1988 to improve the food stamp and commodity distribution programs. We re-authorized the WIC and other child nutrition programs to strengthen the health and nutrition of pregnant women, infants and young children. We expanded housing assistance and economic development programs, and we approved an increase in the minimum wage.

When you think about it, it really is an impressive list of accomplishments; but it is a list of empty accomplishments if all of these programs are not successful in making sure that the people have enough to eat without facing bureaucratic hurdles at every turn. They are empty if people in the Delta have to live in substandard housing. They are empty if babies continue to die because their mothers do not get proper food and health care during pregnancy. They are empty if the welfare system perpetuates poverty instead of supporting and encouraging economic self-sufficiency.

Our witnesses this afternoon are going to tell us how far all of these accomplishments have moved us towards the goal of improving the quality of life here in Mississippi and how far we have yet to go. I look forward to an enlightening hearing, and I would now like to turn the floor over to your congressman, Mike Espy.

Mr. ESPY. Thank you, Mr. Chairman. I have an opening statement. It is rather lengthy. I know that we do not have time for me to go through all of it, and I will not. So I will just ask unanimous consent to have my entire statement included as part of the record, Mr. Chairman.

The CHAIRMAN. Without objection, it is included.

Mr. ESPY. I will just say very briefly first of all, I thank you, Mr. Chairman, for your leadership for bringing the Select Committee on Hunger to Bolton, for bringing it to Mississippi, and for revisiting Mississippi to see ways in which we have improved and sometimes ways in which we have fallen further back in our effort to improve the quality of life for those who live in our state.

I know this is your first time in Mississippi. We hope that we have made you feel welcome and just know that your visit here is appreciated and you are welcome back here anytime.

To my colleague, Bill Emerson, who serves with me on the Agriculture Committee, who, of course, serves with us on the Select Committee on Hunger, and who is the Vice-chairman of the Lower Mississippi Delta Development Caucus, I appreciate his being here, as well.

Eliot Engel, my colleague, a second-term Member from the great state of New York, I appreciate his being here, as well. Eliot says this is not his first time because he has been through Mississippi backpacking. We thank you, too, Eliot, for coming.

Thank you, Mayor Butler, and Mr. Johnson, for the welcome and for allowing us to come today.

Now, I have got a lot here to say, but just let me briefly say that Mayor Butler talked about the children here. I am reminded of a verse that says where there is no vision the people perish. Our vision, quite simply, is just to make sure that these students, these young human beings, in their lifetime will see a Mississippi where people have something to eat, where there is not anyone who has to go to bed hungry, where people always have somewhere to live, where there is no such thing as homelessness and hopelessness, and where no one in Mississippi has to live in a home without running water or indoor plumbing. .

That is the vision that we see. Unfortunately, we have that around us right now. I could go through statistics to talk about the 664,000 Mississippians who presently live in poverty, about 25.8 percent of our state. We know that poverty is really without race. Poverty is both black and white. Mr. Chairman, 11 percent of white Mississippians live below the poverty level, and a staggering 48.6 percent of Mississippians who are black live below the poverty level.

More than one-third of our children live in poverty. Since 1987, the AFDC participation rate has increased from 53,680 families to 59,095 families. Per capita income, up to $8,000 in 1987 from $5,183 in 1979, is still only 67 percent of the national average. Still, too many teenage girls get pregnant at too early an age. We know that even though we have seen the WIC Program cause great reductions in our infant mortality, and we are proud of that, but still too often in Mississippi we have an unacceptable level of babies who die at third world rates.

So we spent $24 billion in food assistance throughout the United States on food and nutrition services, and we just wonder why we are not doing better than we are doing. Are we doing something wrong? That is simply why we have come to Bolton today to hear from the witnesses to see what we have been doing wrong and any lessons that they have to give us.

Where there is no vision the people perish. We are here to bring our vision to Bolton and to take that vision back to Washington to make sure that none of these children can grow up hungry.

Thank you, Mr. Chairman. I appreciate it.

[The prepared statement of Mr. Mike Espy appears at the conclusion of the hearing, p. 39.]

The CHAIRMAN. Thank you, Mr. Espy. I would like to recognize the ranking minority Member of the committee, Mr. Emerson, and I know that he has a few words he would like to say to you. He is from the great State of Missouri.

Mr. EMERSON. Thank you, Mr. Chairman. I have a statement that I will submit for the record, but I do want to say how very pleased I am to be here today with Chairman Hall and your own congressman, Mike Espy, who is a very valued and effective Member of the Congress. I have the privilege of working with him in many different areas, and I am glad to come to his home territory and be with him and with his people.

Mike and Tony and I have been working together for a number of years now on some national programs we hope will help our people gain improved access to food, medical care, education, and housing.

In 1984 I came here to this region for the very first field hearing held by the then newly created Select Committee on Hunger.

I represent the eighth district of Missouri, which is just up the Mississippi River or up Interstate 55, however you want to get there. It is also a part of the Lower Mississippi Delta Region, and it is really good to be back with all of you here today.

We all know what the problems are. I think the question is how are we going to get our arms around them and be able to effectively solve those problems.

I am delighted to be here, and I am looking forward to hearing from our witnesses today and to learning what you think is working, what is not working, and what we need to be doing about it. Thank you for having us.

[The prepared statement of Mr. Bill Emerson appears at the conclusion of the hearing, see p. 45.]

The CHAIRMAN. I would like to now turn the committee's attention to Mr. Engel from the Bronx, New York, a Congressman who has been on the committee now for the past term and see if the congressman from New York has any comments.

Mr. ENGEL. Thank you very much, Mr. Chairman. I want to say it is a pleasure to be here. I have just gotten off the plane from New York. I wanted very much to be here. As your congressman said, this is not my first trip to Mississippi. I have been here a number of times. I have some friends living here and when I was a little younger, did backpack around the country and came to Mississippi.

If the Mississippi Delta represents a symbol of rural poverty in the United States, my home county of Bronx, New York, really is the symbol of urban poverty in the United States. Poverty, of course, is poverty. It does not matter what region of the country you come from. It does not matter whether you live in a countrified area or in a big city. People who live in poverty suffer the pain and the people who suffer the most, of course, are the children.

So as part of the Select Committee on Hunger, I am very interested in learning today more about poverty, more about the problems, more about some of the things that we in Congress can do to help alleviate some of the suffering and help improve living conditions.

I want you all to know, and I think you know it already, but it is good for you to hear it from someone from New York that you have a Congressman in Mike Espy. You should all be very proud of him. He works very hard in Washington and is very, very well respected by everyone in Washington regardless of the party they come from or the region of the country they come from, and you really ought to know that.

So I look forward to listening to the testimony and I thank the chairman and my distinguished colleagues and look forward to hearing from all of you. Thank you.

The CHAIRMAN. Thank you. I would like to begin the hearing by asking Mr. Rims Barber, our first witness, to come forward and take a seat at the witness table. Mr. Barber is the director of the Human Services Coalition. It is an organization which advocates food and income security for low-income persons throughout the state. He has been involved in efforts to end hunger here in Mississippi since the early 1960s. I would like to add that Mr. Barber also served as the executive director of the Children's Defense Fund in Jackson from 1977 until last year.

Mr. Barber, we are very glad to have you. Since there are a number of witnesses, all of your written testimony will be part of the record. We would ask you to try to keep your comments as brief as possible so we can have time for questions and time to question other witnesses.

We thank you for being here, Mr. Barber, and you may begin.

STATEMENT OF RIMS BARBER, EXECUTIVE DIRECTOR, HUMAN SERVICES COALITION

Mr. **Barber**. Thank you, Mr. Chairman.

To the committee, I want to thank you for inviting me once again to speak with you about the conditions of hungry people in Mississippi and the programs that are designed to help them.

I still vividly recall the last visit your committee made to Mississippi and the inspiration that I gained from the late Congressman Mickey Leland. This testimony today is dedicated to the memory of Mickey and also to those people who still must struggle day to day to survive.

We have visited some of those today, and I am amazed that time after time when we go back, we still find the same conditions; that while we have made an impact on a number of people over the years, there are still those that are left behind, whose conditions seem to be unchanged from when we first began this struggle.

Currently, there are just over 188,000 families, households that rely on food stamps for their nutritional needs. This is an increase from when you were last here of about 12 percent. It is also an increase from the time of our highest unemployment, which was back in January to March of 1983.

What this signifies is that even if we have employment, the employment opportunities are not sufficient to enable families to pull themselves up high enough to reach a level of self-sufficiency, so that they are still dependent on some level of assistance because they have not the opportunity through employment to make enough money.

Another factor is we have problems with our service delivery system. It is working at capacity. We have talked with some of your people today about the fact that we have extremely high caseloads. The caseload has risen in the last two years by about 50 cases per worker. That is a significant increase. That means that the workers are having to work harder and longer and probably are making more mistakes because they are becoming more frustrated.

We just do not have the staffing to be able to adequately deliver the services that are needed to these people, and certainly do not do them in a timely way. So these workers are strapped down. They become frustrated, the clients become frustrated and tempers flare quite often at the offices.

We are asking these workers to curtail fraud, to have additional duties relating to Medicaid, child support, and the JOBS Program in addition to food stamps and AFDC, and they cannot keep them all straight. We put them all on one form. It is nearly a 20-page form, and it has seven different sets of rules, each in its own three-inch thick binder. The worker says, well, I have got to figure out what is a shortcut in order to get through this interview in a reasonable time, and they are having difficulty doing it.

So we often find that people do not have their eligibility determined in a timely manner or in a correct manner. In this county, 20 percent of the families do not have the eligibility determined within the federally established time lines. That is a significant problem. If it takes 30 days supposedly by federal guidelines to get food stamps and instead it takes 45 days, you can get mighty hungry in those last 15 days.

We have some private efforts to try to supplement this and give people food while they are waiting to get food stamps, and often—I have to throw this in. You have come here on the first week of a month and people have more food in the first week of the month than they in the last week of the month because of the food stamp cycles. Once you get your food stamps, you run out to the grocery store and you buy a bunch of stuff and you have got a refrigerator full. By the end of the month, it is nearly gone, if not gone by the end of the third week. Then people get very hungry.

So the supplements by private entities is for both the entry time that it takes and for the time at the end of each month when people are hungry again. I notice that people today, when you asked them if they were hungry, said no, we got food. But if you asked them two weeks ago, they would have probably said no, we don't have enough food.

At the Mississippi Food Network, the statewide food bank, we have seen an increase in demand of 15 percent from last year to this year for the first quarter. Each month, we have another eight to 12 food pantries that are springing up across the state who join the network, enabling a greater coverage of the state.

We are very proud of what we are able to do in moving food out to hungry people, but this is no substitute for government responsibility. We must have a policy that no one will go hungry in this country and that the government will ensure that every person will have certain basic needs met. I think we have to start with that kind of a premise and then let us build a system to meet it.

I wanted to comment briefly on the Family Support Act. One of the aspects was the implementation of AFDC Unemployed Parent Program last October. In the six months since that time, we have gotten 112 families on. That is less than one-fourth of 1 percent of the unemployed families in this state, only 112. We have failed to reach the families that fit in this category. There is a great need for outreach to ensure that families in need of assistance know that they are eligible and are able to apply for and receive services. We have to have a system in place that will enable the workers to get these services to them in a timely manner.

The state has also implemented that other major part of the Family Support Act, the JOBS Program, but we attempted to do this as cheaply as possible. As a result, the services to the clients who would like to end their dependency on welfare are minimal. Families are left with many requirements for additional things that they must do, hoops they must jump through in order to cooperate without getting much in return.

Many persons assigned to the JOBS participation got child care vouchers and a public bus pass and were told to go look for a job. That is not an education and training program.

As a member of the Hinds County JOBS Program Coordinating Council, I am concerned that we do not have the resources to offer the clients hope, because that is what we have got to do first, as you so aptly said this morning, Chairman Hall. Let us be gracious to the poor. Let us offer them something real. More than food, more than the job, we need to offer them hope. That is what we can bring if we are going to serve well.

So often, we do not offer them the hope that they need in order to make it from dependent status to an independent status. We have got to find a way to help people develop their natural abilities, find themselves and move forward on a track that will get them somewhere. You met some people who have done that early this morning in Canton, but that is only reaching a fraction of the people who need it.

You know, the first class, I think, had four people who started their own businesses, four out of the 59,000 families that need help. It is a good program, but there are many different ways to reach the goal. Each person has to find their own way, and we need to have a system that facilitates people determining what their future life is going to be. We need a lot of work on that to refine that program to make it work so that everybody can find their niche and work within it, and then we will have real services to offer and not just a series of barriers that you have to pass.

We have made some important gains I would like to say, however, in the State of Mississippi. The biggest one: When the first hunger study was done in 1966 for the Field Foundation, the rate for infant mortality was 35.3 per 1000 live births. Today it is down around 11.7 and falling. There is a commitment, there is political will, and there is some resource commitment of money—Mike we're looking for that—to make a difference. I think we will bring our infant mortality down significantly in the next four or five years.

There is a major impediment to accomplishing that, and that is the kind of poverty that you saw today that saps people's souls, that makes them not know that there is another world out there that they can be part of. If we went out after the rain into some of the fields and saw the water rising and then looked into the eyes of children who sit on their rickety porches that want to cave in and see them staring across the water between themselves and the road, how do we tell them that there is a better life and that they can aspire to it, that they can find ways to get there? I think it is very difficult, and we have got to get to work on it.

In closing, let me point at a list of quick priorities: meaningful jobs and economic activity. We have got to have jobs that pay enough to get people out of poverty. We have got to have them in a way that helps people keep their families together.

We need creative and realistic education and training programs. We need to put more into the JOBS Program than is being put in today in order to really make it work.

We have to have adequate staffing for the programs that impact on the hunger problem because we are so short staffed that I do not know how we get the food stamps out the door every month.

We need an increased commitment from you all to improve the food stamp and other hunger programs.

Today or yesterday I was reading something on the wire that the Senate Budget Committee has put some restrictions in the budget process in their version of the budget bill that would make it more difficult to enact the Leland Hunger Act.

Next week—I think it is on Tuesday—the conference committee will begin meeting and it may meet for only a very short time on the budget. We need the political will to get things straight so that we can enact some creative ways to approach the hunger problem. We do not need a threat to the Leland bill or threats of entitlement cuts in areas such as school lunch, school breakfast, child care feeding, Medicare and farm programs.

I thank you gentlemen very much for the opportunity to speak with you. I will be glad to answer any questions

The CHAIRMAN. Mr. Barber, we thank you very much for your testimony. It is important testimony.

You mentioned the JOBS Program and we talked a little bit about that today. I would like to know what steps will be necessary for the JOBS Program to really start to offer hope for these people trying to work their way off of public assistance. Can you give us some ideas of what you are talking about?

Mr. BARBER. Yes, sir. You visited today the one program that we have really put some money into. That is the first thing. The state made a commitment to put some money into a program that would reach a certain segment of those needing help. Now, the state has not put any money into a number of other programs that are needed for other people. Some need education programs. What we have done has been a referral service that says well, I know of a program that is starting next September. So if you sit tight from now to September, we will get you in it in September.

What we need are some open-ended programs, more creative ways of meeting the needs; finding what the individual need is, and then meeting those needs. If they are educational needs, if they are training needs, I want to see people look for careers, not simply a job today to put a little bit of food on the table that may disappear in the next six months.

The CHAIRMAN. That program we saw today in Canton, was that state monies, federal monies, or both?

Mr. BARBER. Both.

The CHAIRMAN. Both. Now, how did that come down? Did that come to the state and the state decided that they were going to come into the Delta, or what?

Mr. BARBER. There is a national group that promotes the entrepreneurial approach and they came to the state and some people in state leadership positions bought into that program, thought it was a good idea, and wanted to try it on a pilot basis. So we have a pilot program, and there have been resources put into it.

What I am saying is that the mainstream programs are dried up. We are saying well if JTPA has some money, we will shoot our people over there to whatever they have going. We will counsel, we will guide people into existing programs for literacy or JTPA or whatever. But we do not have any programs developed specifically for this clientele except the one you saw today. I am glad you saw it because I think it is an important program.

The lady who runs the program there in Canton, I think, is just gangbusters. She can give those women hope. She sets expectations where they really believe that they can succeed. We need that kind of commitment in all of our programs.

The CHAIRMAN. Questions of Mr. Barber? Mr. Espy.

Mr. **Espy**. I would just like to ask you what improvements would you like to see in the Department of Human Services. I know that we have those here who will testify later, but you talked about caseload problems and burnout problems, problems with frustration. What improvements would you like to see, and do you think that that is really a state problem, or is it a federal problem?

Mr. **Barber**. That is mainly a state problem. There are some interaction of several federal programs that they administer that makes that state problem more difficult. But it is essentially a state problem in that they are understaffed, that the process is too complex, the training is inadequate. They just, because of those kinds of factors, cannot get the job done.

Mr. **Espy**. So that is a state resource problem.

Mr. **Barber**. Yes. I think somehow we need to establish standards of service for the states at the federal level. Now, we say things like you must have your food stamps in 30 days; you must have your AFDC check in 45 days; but we have no guidelines, no standards that say in order to do this, you must have a caseload standard of such and such, a training level of such and such.

There needs to be some more standards set at the federal level so that the states have to put up the money to do the job. Because Mississippi will do it if it has to. But unless we have to, we will lag behind because these are the people that many in high places would just as soon forget that they are there and drive down the interstate and not see those shacks.

Mr. **Espy**. The second question I would ask, Rims, is a question of resources from the federal level. I know that you are an astute watcher of Federal Government spending, and I think you would agree with me that a lot of problems can be overcome if we spend a little bit more money on food, nutrition, and on housing, and I am sure you would agree. But before you answer, let me ask you: You said at the end of your testimony, and you went through it very quickly, but you said something about increasing the money for food and socioeconomic services without threatening a decrease to Medicare, Medicaid, agriculture, and you went through some more.

Let me explain something to you. I sit on the Budget Committee. I tell you, man, we have a $1.3 trillion budget with a $300 billion debt with a lot of competing categories. We now have only three categories of federal spending: defense, international, and domestic. If you try to increase money for one, you have to decrease money in the same category. You cannot transfer it like we used to be able to. We used to say we need to make fewer bombs and missiles and give more to food. You cannot do that anymore, as you know.

Mr. **Barber**. Right.

Mr. **Espy**. So forget taking money from the Philippines because they do not want us there and giving it to hunger because that is in another category. Looking at domestic, if you just told us that you do not want to threaten decreases in Medicaid, Medicare, or agriculture, what would you decrease, Rims, to take that money and find it and give it to the kind of initiatives that we all care about?

Mr. **Barber**. That is a dirty question, Mr. Congressman. I prefer to talk about the problems and what I think it needs to solve some of those problems. I am not prepared to take on the whole federal budget process, which I think you guys goofed up real terrifically last October.

Mr. **Espy**. Well, I will let you go then.

The **Chairman**. Question of Mr. Barber?

Mr. **Emerson**. Mr. Barber, what are the obstacles? I was curious. What are the obstacles or the barriers in the AFDC Unemployed Parent Program that have resulted in only 112 families being certified as eligible under the Family Support Act?

You mentioned the need for outreach, it seems like word of mouth would have caused more than 112 families to become eligible. You pointed out in your testimony that that represents only one out of every 785 unemployed persons in the state.

Mr. **Barber**. Well, I mean only 20 percent of the unemployed people in the state get unemployment compensation. The other 80 percent get neither that nor AFDC-UP. I do not know how they are surviving at all, the 80 percent that get nothing. I think a lot of it does have to do with outreach, that we have drilled in people for so long that the welfare department is where those unwed mothers go, that nobody else wants to go there.

We have got to set about doing some serious image changing to enable people to feel yes, that is where I ought to go. There may need to be some better referral mechanisms. There probably needs to be some refinements in some of the federal rules, particularly in terms of young workers. You have to have worked so many months. I forget exactly how the formula is; six of the last 13 quarters is it, or something like that. That means if you started your working career at age 18, anybody who is unemployed who is under the age of 21 cannot qualify for AFDC-UP simply because there is not a way to have worked six of the last 13 quarters.

So there are some rules in the way AFDC-UP operates that make it difficult for people to qualify, but I think the major reason is that people just have not gone in the door and asked for it. I could not get statistics on how many people applied for it but were turned down. I tried, but could not get that number.

Mr. **Emerson**. Thank you. What practical suggestions would you make for the more efficient delivery of food stamp benefits to the people?

Mr. **Barber**. Well, I think that the application process is too cumbersome and complex for either the client or the worker to understand it. It is too long and too complex. We do too much verification of different things.

I was trying to help out a young man who did not have any milk for his baby or any food for himself and his wife. He was having to prove that he had no income to the Department of Human Services. In order to prove that you have no income, what do you do? How do you verify that? Well, it is easy to verify what I was paid because I have a pay stub that shows it. To have no pay stub does not verify that I am unemployed. Right?

They had written a letter to his last previous employer who did not want to bother with turning and saying no, this guy does not work for us anymore and sending it back in. We finally went out there and convinced the supervisor of personnel they should call the people and check. Right? He says he used to work there and he no longer does. Call them and ask them. Right? We got that done, but that was a cumbersome verification process.

It is verifications of, you know, prove that you do not have any resources. Do you have any bank accounts? If not, at what banks do you not have bank accounts. There are a lot of verifications that are very, very difficult, and people have to jump through a lot of hoops.

Then we run into the child support problems, which is all done for a very noble cause, to get child support for people, but ends up presenting barriers to the person who is applying. I hope we do not tack the child support stuff onto the food stamps as some recent proposals have asked because that is just one more barrier on the AFDC Program.

People go in and they say I want AFDC and they say okay, who is the daddy of this kid and what was his social security number and his last known address. Right? Well, his name was Frank and I met him at the corner out here by the cafe and his social security number was not tattooed on his arm or leg and so I don't know it. Right? And I do not even know his last name.

I mean it gets very difficult to go through that process. People get embarrassed by it. They do not want to talk about it, so a lot of people are put off by the process at that point.

Mr. EMERSON. You have raised a very interesting subject area there. Our object very often is to deliver the assistance to the children and want to ensure that they are getting the food help. The question was asked a couple of times today, as Mike was probing in a couple of situations, what do you do? Sure, we do not want anything bad to hurt the children, but what do you do to bring about responsibility on the part of the father who is not contributing?

I agree with you that child support should not be included in calculating one's eligibility for benefits. On the other hand, how do you bring the father into the loop of meeting the responsibilities to his children where he has flown the coop?

Mr. BARBER. What I am saying is you need to create some incentives for the mother to want to cooperate, not a list. We operate on the opposite way in which we create disincentives if you do not cooperate. I think that negative approach does not work very well, especially with some of the young people.

Some of them are hoping that the dude will come back around and marry them, and he may not. It is unlikely that he will, but she still carries that hope. All right. Therefore, she does not want to turn him in and antagonize him; or she may be so mad at him that she does not ever want to see him again because the last time she him, he whupped her. But we deal with negative things. I think we need to create some positive incentives.

Mr. ESPY. She might be so afraid of him that she does not want him back in the first place.

Mr. BARBER. That is right. We make it very difficult for these people to cooperate easily. As a result, I think the current child support rate in Mississippi is something in the neighborhood of 12 percent of the fathers pay child support. I think that is the latest number.

Mr. EMERSON. I think you have raised a very good yet very sensitive problem area. I do not think we know how to inject into the law those positive incentives. You have thought, obviously, a great deal about this.

I know we cannot be hung up on this subject all afternoon, but I would like to extend an invitation to you. If you have got a range of thoughts on this subject, you might share them with us in writing and send the committee a letter. Mike and I are both on the Subcommittee on Nutrition of the Agriculture Committee which has jurisdiction. We could not get into this subject real easily, if we knew what to do.

Mr. **Barber**. House Resolution 1202 does provide for one incentive and that is to exclude child support from certain food stamp calculations. That would be a kind of positive incentive so that if the woman gets $50 a month child support, then she gets to keep it. She does not have to turn it over to the Human Services Department, wait three weeks and hope she gets it back and how she is going to pay the rent and the light bill in the meantime.

I mean, the typical family in Mississippi who is on AFDC is living doubled up right now. You saw two multi-generation families today, and that is fairly typical to see multi-generational or anyway doubled up because the average AFDC payment in the State of Mississippi is only $115 a month. The average rent for a shotgun shack is around $120, $5 more than the average welfare payment.

You cannot pay the rent, let alone the lights and the water and the gas if you live in town on an AFDC check. So every AFDC family is technically homeless because they do not have enough income to qualify for paying rent and utilities unless they double up with somebody else.

So we have some real problems there where people are just really—we are not talking just about being below the poverty level. We are talking about being at a fourth of the poverty level.

Mr. **Engel**. Mr. Barber, in your testimony, in the second paragraph you noted that that 188,000 households here rely on food stamps for their nutritional needs and you said that was a 12 percent increase since our committee was last here in 1987. I was wondering what you attributed that increase to. To any extent, has the food stamp program outreach and public information services contributed to this increase? Has that been successful at all, or has it really just been by word of mouth or the fact that situations for some people are even worse now so more have applied?

Mr. **Barber**. It is hard to tell for sure, sir, but let me give you one factor I think that has contributed to that increase. We have publicized a lot on Medicaid improvements, which are certified by the same workers that certify you as eligible for food stamps. So we are getting people, new clientele, coming in the door in search of Medicaid, and I think they are also being offered food stamps at the same time. That contributes to the increase in the numbers.

Mr. **Engel**. You also say in the same paragraph that, "The employment opportunities here in Mississippi are not sufficient to" I am quoting you "enable families to pull themselves up high enough to reach a level of self-sufficiency."

Do you have any suggestions that you might offer for spurring economic development in the Delta to assure the availability of jobs? Certainly, jobs are the key to a lot of things that would provide adequate wages to ensure independence from public assistance programs. Because I assume that the situation here in the South is similar in that degree to what we have in northern urban areas where public assistance virtually becomes a way of life. It is impossible or becomes virtually impossible for someone to break out of that cycle because jobs are not available for people.

Mr. BARBER. I am not an economic development expert, so I am reticent. All I know is in towns like this that are too small to have a McDonald's or a Wendy's—I do not want to pick on any particular company—Burger King or Kentucky Fried Chicken. We do not have any of those here. That is a very different economic atmosphere.

In some of our small towns, the only way traditionally you have been able to get a job is to marry into it. Right? There is one mom and pop store or cafe and if you marry their daughter, you will get a job. For half of the community, that may not be even a remote possibility.

Mr. ENGEL. I think that is true in New York, as well, you want to marry into something good.

Mr. BARBER. I do not know the answer to your questions. You know, Mike is doing a lot of things trying to help develop economic opportunities in the district, and I am sure he has better ideas than I have.

Mr. ENGEL. OK, thank you.

The CHAIRMAN. Thank you, Mr. Barber.

Mr. BARBER. Thank you.

The CHAIRMAN. We thank you for your questions. We hope that you, as well as all of the witnesses, keep very close touch with us as to questions that we did not ask and you want us to know. Thank you.

The second panel of witnesses, Ms. Agnes Hinton, Ms. Viola Hudson, Dr. Aaron Shirley, and Ms. Billie Marshall, please come and take seats at the table. Ms. Hinton is a registered dietician who has worked with the State Department of Health for the past 15 years. She currently serves as the director of Nutrition Services. She is also the project director for the Mississippi Surveillance of Severe Pediatric Under-Nutrition Project.

Ms. Hudson is an expanded food and nutrition education program educator with the Partners for Improved Nutrition and Health Program. She learned about this position when she went to seek work at the unemployment office. She was selected for the job and has been there for the past two years. She is also a member of the Partners for Life Program.

Dr. Aaron Shirley is a practicing pediatrician, project director of the Jackson-Hinds Comprehensive Health Center in Jackson. He served as chairman of the board of trustees of the Mississippi Medical and Surgical Association. He also participated in the Field Foundation Service surveys of hunger in both 1967 and 1977.

Ms. Marshall is the director of the Division of Aging and Adult Services with the Mississippi Department of Human Services. This is a position she has held since November of 1989. She previously served as the state long-term care ombudsman and on the advisory council of the National Center for State Long Term Care Ombudsman Resources. You may proceed.

STATEMENT OF AGNES HINTON, DIRECTOR, NUTRITION SERVICES, MISSISSIPPI STATE DEPARTMENT OF HEALTH

Ms. HINTON. Thank you for the opportunity to address you. I would like to speak to four issues. First, the food nutrition needs of low-income Mississippians, with emphasis on children and the elderly; the adequacy of current programs to meet the needs; recommendations to improve public participation and service quality; and progress since the 1987 hearing.

First, I would like to address the known and unknowns regarding the nutritional status of Mississippians. The State Department of Health operates two nutrition surveillance systems through our WIC program for the pediatric and pregnant populations. We have also conducted a special study regarding surveillance of severe pediatric undernutrition.

Our pediatric data for 1989 again confirms the higher nutrition risks of children on WIC. Prevalence rates exceed the expected norms for children of similar age for shortness, overweight, and low hematocrit. Low birth weight is more prevalent and breast feeding less prevalent than expected norms. Prevalence rates for almost all values, however, have shown significant improvements over the last few years.

This again shows the importance of full funding for WIC; the needs for funds targeted to breast feeding promotion, as it is very difficult to increase the values here; and the need for WIC to be closely integrated with health programs such as maternal and child health and Medicaid.

Our pregnancy 1989 data showed a significant prevalence of risk of iron deficiency anemia, obesity, underweight, and a problem with both low and high birth weight infants. Smoking and alcohol behavior before, during and after pregnancy is also reflected through the system. These data underscore the importance of WIC, both during the prenatal and postpartum periods, both times of tremendous opportunity for health education and health service provision which can result in improved maternal and infant outcomes.

The Surveillance of Severe Pediatric Undernutrition Project, funded by CDC, initiated surveillance activity up in the Delta during 1988 through 1990 and in District V, this area, during 1989 through 1990. The project was to investigate the prevalence and cause of severe pediatric undernutrition among children six months to six years of age. I might say, we were told we would not find any children that met that definition.

Our study found a prevalence rate of 2.31 per thousand population of cases meeting the SSPUN definition, or 192 children with 104 from the Delta area. The greatest risk factors for SSPUN were income below 100 percent of the poverty level, a mother 41 to 50 years of age—and that was a little bit of a surprise; we expected to see more teenagers, really, than we did—and being non-white.

Other risk factors included chronic disease, either low birth weight or prematurity, recent hospitalization, and social factors such as a young or undereducated mother and a number of preschool siblings.

Only 5 percent of the cases were classified as due to inadequate food calories, 3 percent to abuse and neglect, and 2 percent due to non-participation in social programs. But again, remember they were telling—these were caretakers of children with health problems telling Health Department employees about what they feed their children.

It should be noted, too, that we did not do door-to-door surveillance, although referrals to the program was promoted among all community health providers and all age-appropriate pediatric inpatients at University Medical Center were included in this survey.

The SSPUN pilot showed us that even participation in programs such as WIC, as 166 of the 192 children were in WIC, even that participation did not preclude these children's needing more intensive follow-up and support for improved health outcomes.

Very little state specific nutrition data is available for any other population group in the state, including the elderly, another nutrition high-risk group. The Department of Health does conduct behavioral risk factor surveillance as designed by CDC, which is based on the results of telephone surveys to randomly selected residents age 18 or over.

I need to point out that the low-income population is likely under-represented in this survey, as only those with telephones are contacted. 1988 survey data includes 13 percent of the respondents 55 to 64 years and 15 percent of respondents 65 years and older. Risk factors in this survey included hypertension, obesity, and sedentary lifestyles. Twenty-seven percent of the 1988 respondents reported having been told their blood pressure was high, with 47 percent of persons over 65 years of age reporting hypertension. Hypertensives were three times as likely to report household income below $15,000 and twice as likely to have less than a high school education.

While the reported prevalence of obesity was highest among 35 to 44 year olds, over 30 percent of those 55 to 64 and over 25 percent of those 65 plus reported being obese and trying to lose weight. Sedentary lifestyles were reported by over 40 percent of those 55 to 64 and over 50 percent of those 65 plus.

While all of this data is significant, we must also recognize how much we do not know still about the nutritional status of Mississippians. Other than the WIC Program, no health programs currently routinely report participant nutrition status data. For example, while both Head Start and EPSDT Programs have a strong individualized health component, there is no aggregate data required regarding basic nutrition measures such as weight or iron status of program participants.

If all existing federally funded health programs for children were mandated to capture and report basic nutrition surveillance information, we would have a much clearer picture of the health status of many of our most at-risk children, and we could do so without initiating costly and time-consuming special studies.

Next, I will address the adequacy of the present programs to meet food and nutrition needs in our state. The WIC Program currently serves 68 percent of the state's potentially eligible population, with an even higher percentage of infants being served. In fiscal year 1990, 70 percent of the babies born in this state were on the WIC program, close to 100 percent of the potentially eligible infants.

Certainly, we do support the need for full funding of WIC to serve all eligible participants in all categories. However, we also recognize that WIC dollars cannot adequately support the health services infrastructure needed for the programs's maximum effectiveness. Increases in funds for MCH Block grant and primary care funds are also needed to assure the availability of quality perinatal and child health services. WIC is to serve as an adjunct to health services, and those health services have to be there.

The school lunch program in Mississippi currently serves around 77 percent of all enrolled children. The greatest problem with our program is inadequate funding to provide quality foods which support the U.S. dietary guidelines. I support the recommendation that an additional five cents per meal be allocated to provide adequate resources for schools for improved food quality. Our school breakfast program, however, serves about two-thirds less children than those served at lunch. We need a state mandate here that school breakfast be offered in all schools.

The Expanded Food and Nutrition Education Program of the Cooperative Extension Services currently operates in about 32 of Mississippi's 82 counties. You will hear next about an innovative marriage of WIC and EFNEP operating in the Mississippi Delta. This program should be available in all counties, and this will require an increase in federal funding for EFNEP.

An estimated 30 percent of Mississippi's elderly live below the federal poverty levels, yet less than 1 percent are currently served by our congregate or home delivered meals programs, an imperative for increased funding.

Additionally, all state agencies on aging should have nutrition professionals on a full or part-time basis to assist in administering the elderly feeding programs. A federal mandate to that effect, and I might add funds to support that mandate, would greatly strengthen both the food service and education components of elderly feeding programs.

Additionally, I encourage Congress to look at innovative ways for existing programs to work together. A coalition of the aging programs, the WIC program, and the Extension Program could deliver supplemental foods and nutrition education to the elderly, for example. While such a program would require additional funds, utilizing existing programs could reduce program costs and minimize start-up times.

Finally, the benefit levels under the Food Stamp Program need to be increased to meet the cost of USDA's Moderate Food Plan. Participation barriers such as complex application procedures need to be reduced, and nutrition education should be offered as a component of the Food Stamp Program.

As to recommendations to improve program participation and service quality, I offer the following: Health care services need to be better triaged. For example, all those eligible for WIC are at some level of nutrition risk and need basic services. However, those at highest risk, such as those SSPUN children we talked about, need intensive intervention with multi-disciplinary case management, home visiting, and health education. By tailoring the intensity of services delivered to the client's needs, scarce manpower resources can be best utilized to improve health outcomes.

Some programs need to be better coordinated or integrated. States should be rewarded for innovative programming that meets clients' needs rather than merely following program guidelines.

A real barrier to quality service delivery currently is adequate staff to provide the level of needed services. Impeding factors include low salaries, which hinder recruitment and retention of the best qualified staff, a lack of physical facilities to house expanded services, and adequate funding for programs.

An additional barrier is the low priority preventive health services receive from consumers, program administrators, and legislators. Too much of our health care dollar is spent in curing severe problems and too little in problem prevention. Increased funding for preventive services, including health education from K through 12, and in professional health related training is needed.

Now, briefly to address some of the progress. We have talked about some of the improvements in the nutrition programs. Some of the improvements you know about. I will mention we do have a perinatal high risk management program, case management program through Medicaid in Mississippi. We have expanded some of our knowledge around nutrition.

I know that many of the Members here have been instrumental in accomplishing this. I thank you for that commitment and concern and just ask that you continue to persevere to assist us in solving these problems. Thank you.

[The prepared statement of Ms. Agnes Hinton appears at the conclusion of the hearing, see p. 52.]

The CHAIRMAN. I want to thank you for your testimony. The committee has just learned about your father. We are very sorry. Thank you for having the courage to be with us. If you would like to leave at any time, please feel free to do so.

Let us just go right down the list. All of your written remarks will be part of the record. Summarize for us. Tell us what you want us to know in your own words.

STATEMENT OF BILLIE J. MARSHALL, DIRECTOR, COUNCIL ON AGING, MISSISSIPPI DEPARTMENT OF HUMAN SERVICES

Ms. MARSHALL. Thank you for this opportunity. Mississippi has been actively involved in providing nutrition and supportive services to the elderly population in the state since the inception of the Older Americans Act of 1965. In fact, Mississippi was one of the first states to implement a nutrition program for the elderly under the Older Americans Act.

We have approximately 430,000 individuals over the age of 60 in our state. Unfortunately, we are able to only serve a small percentage of that in our nutritional program. There are 15,000 persons in our congregate meals program, as well as our home delivered meals program.

Our office recognizes that nutrition is among the many critical factors affecting the health and longevity of older Mississippians. It affects both their morbidity and their mortality. Improving the nutritional status of the elderly is the more practical of all approaches for expanding life expectancy and compressing the period between morbidity and mortality.

Although the economic status of many older persons has improved in the past 10 years, many elderly Mississippians still fall into the low-income group. These persons have always had a low level of income and old age merely propels the problems of a lifetime of poverty or near poverty.

Elderly blacks as a whole in this state are more economically disadvantaged. Though there are fewer poor blacks than poor whites among the aged in this state, the proportion of elderly blacks who are poor outweighs that of the white population.

The effects of a declining U.S. economy, especially that of Mississippi, with its spiraling rate of inflation, diminishes the purchasing power of persons living on relatively fixed incomes. The amount of income spent on food is often very limited. It is unfortunate, but most food purchases made by the elderly are for items which contain starches and fats. High protein and minerals are not the food groups of choice. The elderly, especially the black elderly, often purchase foods that are cheaper and a quick source of energy such as these starches.

Realizing that there is a correlation between age and low income, the economic status must become an important concern of those who are deeply committed to food and nutrition issues and policies for the elderly. While the economic well-being of the elderly has been improving, findings in a recent report published by USDA indicates that there is a substantial substrata of low-income elderly, especially the older old and those living alone that are economically vulnerable and at nutrition risk.

Mississippi's elderly profiles are consistent with these findings. Because Mississippi is basically a rural state and in small towns the population of older individuals is sparsely located and isolated, the problem is compounded and these individuals are placed in double jeopardy.

Nutritional risk factors include but are not limited to diabetes, obesity, hypertension, congestive heart disease, stroke, and cancer. In addition to the elderly low-income characteristics, most of Mississippi's elderly live on fixed incomes, while retail food prices increase rapidly.

It is interesting to note that although the Food Stamp and Commodity Programs are available for a number of people in our state, very few elderly people participate in the Food Stamp Program. Many of them do not participate because first of all, they have a problem with transportation, accessing the system in terms of being able to become eligible for it, and often they do not understand what the criteria requirements are as far as the Food Stamps Benefits Program is concerned.

Many elderly are unable to go to the food stamp office, stand in line and present themselves, which is a requirement of USDA, that they must be able to come in person to certify. It is interesting to note that in 1985, we did a needs assessment of the elderly people in Mississippi. We did not, of course, have an opportunity to interview all elderly people; but we did interview a number of representative people.

Of that number that we were able to interview, we calculated some of our findings of that 430 population. Of that number, we found that 96 percent of the elderly know about the Food Stamp

Program, but only about 36 percent actually participate in the Food Stamp Program.

There is one other issue concerning the problem of population. I would like to make the following suggestions, which I think address the lack of available financial and human resources.

First, I believe the federal regulations governing the certification of participation in the Food Stamp Program should be reviewed. Attention should be given to mail-in certification procedures which would allow the isolated and immobile elderly to take advantage of a truly needed service to supplement their food budget.

Second, that programs should be developed and implemented at the federal, state and local levels that are truly health promotional and disease prevention for elderly persons in both urban and rural areas with a greater emphasis on the rural, isolated elderly.

Third, that funding be increased for nutritional screening, counseling and education that will have a lasting impact on the health longevity of the elderly.

Four, that the U.S. Department of Transportation target more resources and programs for rural transportation services in the geographically rural areas of the state.

Lastly, that the Federal Government provide for leadership of state and local governments to engage in in-depth futuristic planning for the diverse population of 60 plus. Coordination and collaboration must become a major priority in planning, policy development and implementation of programs for the elderly. Thank you.

[The prepared statement of Ms. Billie Marshall appears at the conclusion of the hearing, see p. 94.]

The CHAIRMAN. Thank you. Doctor?

STATEMENT OF AARON SHIRLEY, M.D., JACKSON-HINDS HEALTH CENTER

Dr. SHIRLEY. Mr. Hall, Mr. Espy, Mr. Engel, Mr. Emerson. The statement I am going to make is going to deviate a little bit from the letter of invitation. I wanted to cover some areas that I think are important for your consideration.

As a participant in numerous hands-on studies of poverty and hunger over the past 20 years in this country, the issue of malnutrition and education is of special interest to me. Before getting into specific implications of malnutrition and education, I think we ought to take a look at the extent to which poverty and hunger with resulting malnutrition exists.

There is really no precise way of knowing how many hungry people there are, but there are methods, fairly reliable I think, which can be used to estimate the dimensions of the problem. Based on these, there are probably 20 million Americans who suffer from hunger on an ongoing basis. The majority of these, about 15 million, are people who live below the poverty line but who receive no food stamp assistance.

The remainder are individuals and families who receive food stamps, but for whom the program is inadequate and those who make up the near poor who are unable to make adequate food stamp purchases for nutritionally adequate diets.

These figures in themselves are disturbing enough, but when we take into consideration the fact that hunger and malnutrition are directly related to poverty, that 12.5 million American children live in poverty, and that 7.3 million of these are subjected to hunger on an ongoing basis, they take on added significance.

So what are the implications for education? Considerable evidence shows that maternal malnutrition during the prenatal period or infant malnutrition during the early postnatal stage can produce lasting damage to the structure and function of the developing nervous system. This damage is linked to long-term developmental deficits which manifest themselves by early childhood.

Brain structure, itself, is uniquely vulnerable to damage during the intrauterine period. Beginning shortly after conception and extending until about the age of two years, the brain experiences maximum growth to about two-thirds of adult brain size. During this period the brain has abilities that do not extend into later life.

The absence of adequate nutrition during this critical period can produce permanent deficits in brain size, deficits which may not be reversible later even with ample nutrition. Survivors of severe childhood malnutrition show deficits in head circumference which reflect brain size. Malnutrition during this period is associated with identifiable structural deficits in the brains of children. Such deficits extend into adult life.

All children who suffer from growth retardation have at least one organically based medical disease, that is malnutrition. There is a growing sense among some practitioners and scholars that the later educational performance of poor children is strongly affected by their health, nutrition, and home environment, especially in their earliest years. Studies suggest that improved and coordinated health, education, welfare, nutrition, and child development services for poor families will pay substantial dividends in later educational achievement.

There is a tendency to look at poverty, hunger, malnutrition, and poor health as separate entities. None of these occur in a vacuum. The income, health, education, nutrition and other service needs of poor families are interconnected. I believe that clients are most effectively served when their problems are addressed as a unit.

Not only must a variety of services be available to children and families, but they should be easily accessible and available in combination. This might be achieved either through the co-location of service agencies in the community or by establishing some sort brokering/case management function through an existing or new agency. Such brokering should include or could include:

—assessment of family needs, including the establishment of an improved database;

—early problem resolution;

—orchestration of specialized services and support on behalf of the family, including better access to the variety of services which already exist.

How do we begin to achieve some of these broad goals? A substantial first step is for individual communities to establish a series of specific outcomes which will focus the community's energy and offer both immediate and long-term improvements in children's lives.

These might include a higher level of community awareness of the condition of its children and a higher level of community expectations for improving that condition; fewer low birth weight babies; a lower rate of adolescent childbearing; a lower incidence of preventable illness among children; a higher level of cognitive and social functioning among young children, both pre-school and in school; and fewer families depending on public assistance and more families earning an income adequate to meet their needs.

None of these are beyond the boundaries of our knowledge or resources. They are outcomes that are reasonable and achievable with interventions that are known to be effective. Moreover, they are measurable, allowing each community not only to make a public commitment to its children, but also providing the means to assure that that commitment is fulfilled.

I thank you very much.

[The prepared statement of Dr. Aaron Shirley appears at the conclusion of the hearing, see p. 110.]

The CHAIRMAN. Thank you, sir.

Viola.

STATEMENT OF VIOLA HUDSON, VOLUNTEER NUTRITION EDUCATOR, PARTNERS IN NUTRITION AND HEALTH [PINAH]

Ms. HUDSON. Good afternoon. I am Viola Hudson from Hollandale, Mississippi. I am the mother of seven children. I am a member of the First Baptist Church of Hollandale, Mississippi. I am a sponsor for the Jog-A-Thon for Novata High School Track and Field, and I give donations to different charities: cancer, heart, and leukemia. My family participates in the School Lunch Program and the Food Stamp Program.

I am an EFNEP educator with the Mississippi Cooperative Extension Service. I have worked as a Nutrition Educator Program assistant for two years and two months as of today. EFNEP stands for Expanded Food and Nutrition Education Program. EFNEP is now working in partnership with the Health Department's WIC Program and Partners for Improved Nutrition and Health, better known as PINAH.

For over 20 years, the Cooperative Extension Service has offered nutrition education nationally through a home visitation program to low income families. In 1988, the Mississippi Cooperative Extension Service, the State Health Department, and the Freedom From Hunger Foundation formed a partnership called PINAH, Partners for Improved Nutrition and Health. And through the PINAH, the Partners for Life Project was developed.

Last fall, the Partners for Life Project came to our county, and we have been working in Washington County, Mississippi, to deliver this program to our clients. We know you have the numbers about infant mortality and low birth weight babies. Over the past five years, more than 87 babies died in our county before the age of one year. In 1989, about 137 babies were born with low birth weight. This means the babies weighed less than five and a half pounds at birth. Low birth weight means higher mortality and learning disabilities.

The Mississippi Cooperative Extension Service is trying to combat these problems, but they cannot do it alone. That is why we need your support so that we can have more healthy babies than low birth weight babies.

We have trained local program assistants in nutrition, maternal and child health, and parenting. They are known as EFNEP educators. When a WIC client meets with an educator, she can learn how dieting affects her baby's health and happiness, what to expect during her pregnancy and childbirth. She will learn how to care for her newborn child and why breast feeding is so important for her and the baby. She will learn where to go for community resources, and we also show her how to get information that we do not know of. The information that we received from our training is carried back to the community to share with our clients in a one-to-one setting, or with two or three other clients, or friends, or family members, or with a small group, whichever way is comfortable with clients. You cannot just pick up your settings.

Out of these lessons, you get more educated and wiser of life and comfortable in knowing what they are doing before the birth and after the birth of their child. I have learned a whole lot in educating my clients and also myself. I have learned how to communicate with them in their settings of life and how to give them understanding, caring and support whenever it is needed, without regrets.

I have 36 clients that I am now working with and most of them are teenagers. We get the majority of our clients through the Health Department, some in the community, others through conversations with my clients' friends, and also through WIC if they are eligible. They are referred by their families, by someone I have already enrolled sometimes, or even by their mothers.

One of the main things we as EFNEP educators stress to our new mothers is to keep all of their doctor or clinic appointments. We tell them to get all of their required servings of milk, to eat a variety of food to get all of the nutrients they need, and to get four servings daily of fruit and vegetables to feel fine. We encourage them to exercise. We tell them about the danger signs, to avoid alcohol and drugs, how to control fatigue and stress, and how important it is to gain the right amount of weight.

There are 24 other educators in five Delta counties in the Partners for Life EFNEP Program. We think Congress ought to expand the EFNEP Program so that any woman can have this support during her pregnancy and have a healthy baby. I hope that once you have heard what I have said, you have a clear heart and mind and understand that we need your support 100 percent. You could really make life and society better, not only for this generation, but for the generations to come.

Thank you very much.

[The prepared statement of Ms. Viola Hudson appears at the conclusion of the hearing, see p. 59.]

The CHAIRMAN. Thank you for your testimony. We thank all of you for your testimony, and we have some questions. We have a lot of questions, but we are not going to get to all of them. The questions we do not get to, we would like to submit them to you and ask you to respond them to by letter, if you would.

Ms. Hinton, I would like to ask a question about the WIC Program. You stated that you recognize that WIC dollars cannot adequately support the health services infrastructure needed for the program's maximum effectiveness. What are you saying there? What do you mean?

Ms. HINTON. What I am saying is that WIC is to be an adjunct to health care, but health care has to be there for it to be an adjunct to, to put it into vernacular. Right now, we are serving about 67 percent of our potential eligibles for WIC. Our limitation on serving more is really not WIC dollars in Mississippi. Now, that is not true in every state. We know in some states they need expanded funding to be able to serve more.

Our problem is that our clinics are maxed out. Dr. Shirley's clinic is serving WIC assisting every one of our Health Department clinics. We are going to have to have more staff. We are going to have to have expanded facilities to be able to reach beyond what we are serving now, and WIC dollars, as they are currently set up, do not pay for that. WIC dollars pay only for nutrition education and the actual foods.

So all of the things that have to go to support that cannot be funded through those dollars. That is why I am saying that it is so important that we coordinate with MCH services and that both MCH and primary care dollars are adequate so that that infrastructure can be there.

The CHAIRMAN. So in other words, even if we have full funding of WIC——

Ms. HINTON. It will not necessarily solve the problem everywhere because you have to have the staff to be able to deliver WIC services.

The CHAIRMAN. OK. I would like to ask the question either of Ms. Hinton or Ms. Hudson. I am not sure which. It is on breast feeding. I think it was Ms. Hudson who said in your testimony that you encourage your clients to breast feed. How successful is this?

Ms. HUDSON. Some of them do and some of them don't. Some of them are afraid because they have never experienced it before.

The CHAIRMAN. They are afraid because of what?

Ms. HUDSON. It's something new to them. You know, they remember when their mother did it, but you know, this generation here, they're dealing only with bottles.

The CHAIRMAN. Because they are being brought up on the infant formula and they have been sold the fact that this is the greatest thing since sliced bread.

Ms. HUDSON. Right.

The CHAIRMAN. When, in fact, we want to get our mothers to go back to breast feeding.

Ms. HINTON. May I respond to that, Mr. Hall?

The CHAIRMAN. Right.

Ms. HINTON. Now that we are really putting some expanded efforts into breast feeding promotion, we are slowing seeing some increases, but it really takes a lot of support to overcome the obstacles to breast feeding. We cannot just give lip service to it. We have to have peer counselors. We have to have health professionals who are properly educated.

Certainly the WIC dollars set aside for breast feeding have been very helpful. That needs to continue. I think as we see increased support for breast feeding, we will see those numbers slowly rise. But we cannot just assume that even if the woman is convinced that breast feeding is best, that she can be successful without quite a bit of support.

The CHAIRMAN. Do you have peer counselors?

Ms. HINTON. Yes. We are beginning counselor programs through the State Health Department. We have it now at three of our nine health districts. So we have it in about a third of the state now, and we are planning to expand that as dollars are available.

The CHAIRMAN. Doctor, you stated that about 15 million people who suffer from hunger live below the poverty line but receive no food stamps. What do you perceive as the problem that these people fail to qualify or fail to get on the program?

Dr. SHIRLEY. During some of our tours with both the foundation and the Harvard group, in talking with individuals who were not traditionally dependent on public assistance, there is a greater degree of stigma attached to the use of food stamps, and also, the hassle that many of them had to go through, as Rims Barber described, just prevents them from actively seeking to participate.

The CHAIRMAN. So it is more of a stigma than not knowing about it. Would you feel that most people are aware of what is available?

Dr. SHIRLEY. Most people are aware that they are available. They hear so much. They get a lot of bad information through the press. I think we had a recent president at one time that raised the issue to the point of making especially elderly individuals ashamed to apply for and use the food stamps.

The CHAIRMAN. OK. Questions of the witnesses?

Mr. Espy.

Mr. ESPY. Thank you. I want to compliment all of your testimony, very interesting and very compelling. But as the Chairman said, we have got a lot of questions and not a lot of time.

Agnes, I really do thank you for your testimony and offer my condolences, for your loss. I want to ask you a question.

You talked about the school breakfast program serving so many fewer students than the school lunch program, two-thirds fewer students, I believe, that you serve on the school lunch program. What is the problem, and why can we not do better than that?

Ms. HINTON. Well, for once, you are not the problem. I do not believe that the feds are the problem. I do believe a lot of the federal improvements have been made in school breakfast—the problem, I think, now lies within the state. The school system must accept the responsibility for providing school breakfasts statewide. We had legislation introduced in our state legislature the last two sessions, which has failed. It did not even come up for a full house vote this time, so we just have to persevere to see that legislatively, if we have to, or continue to encourage our school systems to provide this service to their children.

Mr. ESPY. So we can do that. There is a program in Washington called—or used to be a program called Healthy Babies Right From the Start. Each morning as I was dressing to go to Congress, I would turn the radio on and there would be the D.C. Administrator of Human Services. He would have some enthusiastic message about prenatal care, avoiding teen pregnancy. It seemed to be a well-coordinated program through television and radio.

District of Columbia, of course, has a high rate of infant mortality, higher still than Mississippi. But I thought that was a pretty good program and something that I am not really aware that we are doing in Mississippi, using the radio to actually get into homes. I may be wrong, and that is what I want to ask you about because EFNEP is a great program, Viola.

As you went through your testimony, you talked about one-on-one counseling. You have talked to them, sit them down and talk to them about how much weight to gain and how to breast feed and all of that. My district is very rural, very rural; and we have problem with access.

How are we going to create the kind of excitement, Dr. Shirley, that you talked about, create the kind of awareness that you talked about, and also create the kind of one-on-oneness that you talked about, Viola, to take care of some of these grinding problems that we have? Do we have a radio campaign like that? Do we use T.V. enough? What are we doing wrong?

Dr. SHIRLEY. I think the potential for a radio campaign exists in that we have a network of public radios through the state DTV system. We have a couple of commercial stations whose signal reaches into the Delta. I think it is a good point that those of us who are health care providers, and health educators, and advocates, maybe we should take a look at this potential and see if we can get some commitments for public service time to do just that.

Mr. ESPY. I would encourage it. This community awareness that you talk about, it seems to me the key is access and excitement, you know, access and excitement. How do you create community awareness and expectation, Dr. Shirley? I mean, is it in the leadership, people that you elect or do you have to have mobile health vans to actually go out from the clinic to the home and deliver these services, or all of the above?

Dr. SHIRLEY. All of the above.

First of all, the commitment has got to be there. I think one point I was trying to make in terms of mentioning the consequences of chronic malnutrition, I think if we could convince our leaders and people in the legislature and people in Congress that it is a good investment to see to it that especially our children have adequate nutrition so that they can grow up to be productive citizens, they can be good soldiers, they can push the right button on the missile thing.

If we could just convince them, then there would be more of a will, not just at the national and state level, but even right at the community level. If we can get a campaign to educate everybody, especially those who make things happen, as to the consequences, the adverse consequences that result from individuals being chronically malnourished.

Mr. ESPY. Viola, on your EFNEP counseling sessions, how long does each person in the household participate in the classes? In an average span of pregnancy, really how many times do they come?

Ms. HUDSON. Well, I go to them. I go to their homes.

Mr. ESPY. You go to their homes.

Ms. HUDSON. I go to their home. I enroll them in the Health Department. Then I set up a date for them to give a visitation out to their homes. I be there at that time because we make an agreement to each other. Then once I there, we start the lesson for whatever we are going to do that day. If the family is there, I do it with the family, also. It lasts maybe an hour, sometimes two, sometimes three, whatever. You know, however they want to go, I go.

Mr. ESPY. Do you have a lot of trouble?

Ms. HUDSON. I don't have no trouble.

Mr. ESPY. Do they participate willingly?

Ms. HUDSON. Yes, even the grandmothers, grandfathers, cousins. I handle it.

Mr. ESPY. How about boyfriends?

Ms. HUDSON. Oh, yes, all of them. They're all excited, too. Some of the mothers they be in their last month when I enroll them, but they want me to come every week because we have eight lessons. They want to get those eight lessons before they have their baby, so I go back and give those eight lessons, sometimes two lessons a day, sometimes three just to get it done. I have to make them happy.

Mr. ESPY. One last question, if I can, of any of the witnesses. We are thinking about going, and there are demonstration projects to go from a food stamp voucher to an electronic credit card, basically, where you have an account every month. It is just in your name. It is your account, and once you go to the supermarket, you will go to the aisle and hand them—you know, you buy your food and you hand them your food stamp credit card. Then they will draw down from your account.

This is being done. I think there is a demonstration project in—what is it, Bill? Is it in Baltimore?

Mr. EMERSON. Yes.

Mr. ESPY. Do you think something like that will work in Mississippi? You are talking about stigmas attached to folks on food stamps going into the lines and having to use coupons. How do you think that would work in rural areas?

Ms. MARSHALL. It is interesting. I am not really sure how it would work in rural areas, but nowadays people use ATM bank cards all the time. So I guess it is the same premise as that. Perhaps it would work well if you have a large chain of food stores that have a variety of foods. But still there are going to be some problems with transportation so that they could access and utilize the card. Of course, there are going to problems with the eligibility certification, which is one of the biggest problems with older people.

But that is something interesting and I think it would be good to try it, but I still do not think that is going to solve the whole problem for us.

The CHAIRMAN. Mr. Emerson.

Mr. EMERSON. I want to thank each of you for your very valuable testimony here today. I think where each of you is coming from, you really have some interesting and valuable perspectives to share with us. What I wish I could do is spend a day with each of you in the pursuit of your daily responsibilities. I think we would learn an immense amount. Maybe sometime we could do something like that. I do not know if we could take four days.

I recently spent the better part of the day with home health care delivery people in my district, nurses who go to administer health care to invalids in their homes. You go and you see and you learn so much that you just cannot glean from the stated word. I think that each of you must have real challenges in the lines of work that you are pursuing.

I think your testimony has been outstanding and will be of immense value to us. I think, Dr. Shirley, you made a very powerful statement that I will use in furthering my goals of one- stop shopping, the consolidation and integration of services. You made a profound point as it relates to the delivery of care to infants, and that can be interpellated and used in the whole welfare system, as a matter of fact.

I just want to thank each of you. I do not have a specific question. We may get back to you in writing. I assume we will have that opportunity, Mr. Chairman, to submit questions in writing. I thank each of you for your very, very valuable testimony here today. It is immensely helpful, and we really appreciate your cooperation and the time that you took to be with us and the trouble that I know you went to to assemble all of that material to present to us in such a meaningful way. Thank you.

The CHAIRMAN. Mr. Engel, do you have any questions?

Mr. ENGEL. I have a lot of questions, Mr. Chairman, but I know we are pressed for time. So I will submit all of them. I just have one quick question that I was wondering if Ms. Hudson could answer. I wanted to know what are the most common nutrition problems that you see in your work, and I wanted to also say that I have seen research that low income families in rural areas have very limited access to fresh fruit and vegetables. I was surprised about that. I was wondering if that has been your experience.

Ms. HUDSON. Could you give it to me again?

Mr. ENGEL. What are the most common nutrition problems that you see in the people that you help?

Ms. HUDSON. A lot of young teenagers getting pregnant and without any counseling. Really, I say without any counseling because there are just too many of them. They are pregnant, but they are not coming to the Health Department until the last month of pregnancy. I wish that we could get in contact with the ones that are at home hiding out so that we can talk to them ahead of time so they can prevent infant mortality.

Mr. ENGEL. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Again, we want to thank you for your testimony. We will be submitting some other questions to you, and we thank you so very much.

On our final panel, we have Ms. Beatrice Branch and Ms. Carolyn Moore. Ladies, if you would come up to the witness table.

Ms. Branch has been the director of the Mississippi Department of Health and Human Services since February of 1990. Before her appointment to this position, she was the executive director of the Mississippi Governor's Office of the Federal-State Programs. She also spent some time as Director of the Administrative Section of the Library of Congress in Washington for 15 years.

Ms. Moore is a graduate of Mississippi Self-Employment Initiative Demonstration Project. In 1989, she opened her business, which was Moore's Janitorial Service, and is now working her way to complete economic independence as an entrepreneur.

We are very pleased to have you this afternoon.

Ms. Branch, would you start off?

STATEMENT OF BEATRICE J. BRANCH, EXECUTIVE DIRECTOR, MISSISSIPPI DEPARTMENT OF HUMAN SERVICES

Ms. Branch. Thank you, Mr. Chairman, Congressman Espy, and other distinguished Members of this committee. On behalf of Governor Mabus, I welcome you to Mississippi. I want to express my appreciation for you all allowing me the opportunity to come this afternoon and talk about hunger and poverty in Mississippi. Of course, I have submitted all of these comments to you all, and I am certainly not going to go through all of these pages.

In my short tenure as executive director of the Mississippi Department of Human Services, I have observed a number of things. As executive director of the Governor's Office of Federal-State Programs, I am proud to say that I was a part of the leadership that came up with the innovative idea of the self-employment initiative that this lady has participated in.

One of the things that I have observed since being in a leadership role in Mississippi deals with the fact that I think we need to get more people to administer these programs that are creative and innovative in their thought process. One of the things that I was confronted with when we started talking about the special initiative in working with staff and other agencies is we cannot do it because the regulations will not allow us to do it. We said to the people we do not want to hear what we cannot do, we want to talk about the possibilities of things we can do.

Had we accepted the attitude that we cannot do because the regulations will not allow us, then we would not have had the self-employment initiative program. We certainly had to get waivers from the Federal Government in order for these clients to participate, but I think you all have witnessed today that it is a very, very beneficial program. Certainly, that is something that I hope that welfare reform will eventually allow states to do, to get involved in entrepreneurship programs. Because in a state like Mississippi we can train clients and provide services for them, but in my estimation because of the type of positions that are available in the state, most of those persons will always be eligible for some kind of service that this agency provides, and that troubles me tremendously.

One of our issues certainly has to do with our level of state funding. We are not maximizing the number of federal dollars that we could have in Mississippi for the JOBS Program. That is because the state legislature, instead of giving us the amount of money that we requested, which was approximately $4 million, only gave us about $2 million. So as a result, instead of realizing a $16 million JOBS Program in this state, we only realized an $8 million program in the State of Mississippi.

As a result of that, we had to cut back on the number of counties that we were going to serve. This first year we have nine counties.

Hopefully, starting in October we will be able to bring on an additional seven counties. But if we had the funds at the state level for match, we certainly could access more the federal dollars for an increase in job services.

In Mississippi, eligibility for JOBS is determined by local MDHS economic assistance eligibility workers. Mr. Barber talked about the caseloads that the eligibility workers have. Now, of course, the JOBS Program just compounds that situation. It adds anywhere from 45 minutes to one hour of additional time that an eligibility worker must spend on working with a client.

We feel certain that because the eligibility workers are already overworked and a lot of them face burnout, etcetera, and are likely to make more errors, we are going to be sanctioned. We feel certain of that. We have tried to convince the legislature that we need more positions to serve the clients, but we have not been as successful as we had hoped. We are also using the umbrella of the Community Action Agencies for jobs service delivery, and we are relying on a network of resources provided by those local entities. Licensed social workers' provide case management services to job participants. We also have a memorandum of understanding and other arrangements that are used as tools to facilitate the availability of various resources to participants.

Today, we have established a memorandum of understanding with a total of 11 agencies in Mississippi. An example is the State Department of Education and the State Department of Economic and Community Development, which administers the Job Training Partnership Act Program and the transportation program for our state. We don't intend for those documents to become meaningless pieces of paper. They are being used to negotiate real services.

Coordination is somewhat of a watchword for the program, thus local coordinating councils have been established for each JOBS Community Action Agency service area to provide a vehicle for resource coordination and program ownership by the community. Some of the work of these councils include client access to community resources, identifying community resources gaps, and developing a plan for seeing that those gaps are filled, including those applicable to job creation.

Approximately 202 citizens from both the public and private sectors are currently participating. At least 16 are JOBS-AFDC participants, and 21 are from the business sector. We know we must have these partnerships if this program is going to be successful. We clearly consider the use of community action agencies to provide JOBS case management and the establishment of local coordinating councils to be innovative.

There are also other innovative program features which I would like to mention. We are utilizing the Department of Education to administer a test of applied literacy skills which measures the participant's ability to perform quantitative operations and to read documents in the context of simulated open-ended tasks. This is a deviation from the typical assessment measures which usually is a literacy level test to determine the grade level of an individual.

We are using VISTA workers to provide assistance to the case managers in accessing educational resources and providing emotional support and encouragement to the participant throughout the educational process.

As we all know, the Job Corps Program is a residential program. But what we are going to do in order to utilize that program for our clients is to transport our clients to and from those programs each day. Other program strategies are being proposed to assure that we maximize the use of all available resources and allow for ongoing input in the planning process from those whom we serve.

While I am enthusiastic about our JOBS Program, I do not want that enthusiasm to overshadow the many administrative and programmatic areas which continue to exist. To begin my list of concerns, coordination is indeed an important element of the JOBS Program. Many services that AFDC clients utilize to sustain their families provide conflicting eligibility and program participation requirements which seem to defeat rather than promote the goal of assisting families to independence.

As a simple example of that, the majority of families in Mississippi receiving AFDC benefits also receive food stamps. The two federal agencies administering those services both have employment and training programs. However, there is only marginal evidence of any coordination regarding those programs occurring between the two agencies at the national level.

While there seems to be great willingness on the part of both agencies to work with states on a case-by-case basis to assure coordination of the employment training programs at the state level, it would be extremely beneficial if policies and regulations for those programs could be made more compatible at the national level.

Since October 1, the JOBS case management unit, as I said earlier, is in nine counties. We have 18 case managers and eight supervisors. We have received nearly 2,500 referrals, which is contradiction of what you heard earlier. We have actually 2,500 referrals, not 112. As I shared earlier, I have provided written comments which I hope you will have an opportunity to thoroughly review; therefore, I am going to end my testimony. If you all have any questions. I will be happy to entertain them.

[The prepared statement of Ms. Beatrice Branch appears at the conclusion of the hearing, see p. 104.]

The CHAIRMAN. Thank you, Ms. Branch.

Ms. Moore.

STATEMENT OF CAROLYN MOORE, PARTICIPANT, SELF-EMPLOYMENT INITIATIVE DEMONSTRATION PROJECT (SEID)

Ms. MOORE. My name is Carolyn Moore and I am here to testify before the House Select Committee on Hunger.

I was on welfare for about one year. I was the only one of my six sisters and brothers to not finish school and to end up on welfare. After my divorce from an abusive marriage, I ended up on welfare. I went to apply for that child support that my ex-husband owed, but I ended up on AFDC.

I started looking for a way to get off welfare, but jobs were hard to find. I could not find any work. So one day, I found a letter on my door about starting your own business to get off welfare. I could not believe it. I kept the letter around in my purse for about a week, trying to decide whether or not I should go to the orientation because I thought it was just—I just did not believe it was true. It was sponsored by Friends of Children. I am a Head Start parent and I know Head Start is a name you can trust.

I went to the orientation and I liked what I heard and I went on to enroll. Now I know, finally, through the program, I can take care of my three boys. I just want people to know that even though you do not have much education, you have skills and talent that you still can do some productive work. Now I have an income of about $1,500 a month and what I received on AFDC was only $144 a month, and I had to take care of three boys.

When you are on welfare, your self-esteem is low. People put you down because they do not think you want to do anything. That is not true. Having children will make you want to do something because my biggest fear was that one day I wouldn't receive AFDC or welfare or food stamps. And I was just afraid. Every night, I would lie down wondering if I was going to get my check or food stamps for the next month.

So I just want everyone to know through the program, my self-esteem was up. I go to work every day and I receive a check. And I just want the SEID Program to know how much I appreciate what I went through with them and what they went through with me because it was hard, but it was not as hard as it was on my children every day. So I did it for them, and I want to say that I love them.

[The prepared statement of Ms. Carolyn Moore appears at the conclusion of the hearing, see p. 62.]

The CHAIRMAN. That is what we need to hear. You are to be congratulated. It is wonderful to see you, to listen to your testimony about your life and what you are doing. We congratulate you.

Ms. MOORE. Thank you.

The CHAIRMAN. You mentioned something about it picked you up and encouraged you and helped your self-esteem. How do they do that?

Ms. MOORE. Well, staying at home and not working, I was feeling bad, just at home not finding work. It makes your self-esteem low. But going out there and seeing that I was not the only woman that was in that kind of shape, having no job and had children who had to be fed, the more I went to the program, the more I went to school for the training, the more I was seeing myself feeling better, outspoken.

I would not have ever come out and told anyone that I was on welfare because I was ashamed. Now, I can talk to other women about it, other people, and let them know. I was ashamed because I was the only one in my family, being the oldest and on welfare. And I was just ashamed. I couldn't hardly face my children in the morning time. And so then I enrolled in the program. I sat down and talked with them and they told me it would be hard work, long hours, and they were willing to hang in there with me.

Right now, my 15-year-old goes to work with me mostly every evening and he has money that he can put in his pocket and buy clothes and stuff.

The **Chairman**. What kinds of assistance do you still receive while you are making this transition?

Ms. **Moore**. Well, I was able to stay on a waiver for a year to receive my food stamp and AFDC while I was running my janitorial service. And I was able to save my money to put back into my business. After my year was up, my benefits will be cut off.

The **Chairman**. How long has that been?

Ms. **Moore**. Sir?

The **Chairman**. How long has it been since you have been off of that?

Ms. **Moore**. It's been since November.

The **Chairman**. Since November?

Ms. **Moore**. Um-huh.

The **Chairman**. And you are doing okay.

Ms. **Moore**. Yes.

The **Chairman**. And you are making enough money to take care of your concerns and needs.

Ms. **Moore**. Yes, I sure am.

The **Chairman**. Tremendous, great.

Ms. **Moore**. Thank you.

The **Chairman**. Any questions of the witnesses, Mike?

Mr. **Espy**. I said I would be real brief, and I am going to be brief with respect to the time and patience of the audience.

Bea, what are the barriers to expanding the program that Carolyn graduated under? You talked about state funding, how the state reduces funding to the JOBS Program, which meant that you had fewer dollars to leverage federal match. You know, that is not going to change. That is not going to change. What are the opportunities? I mean, the program that Carolyn graduated under is exactly the program that needs to be replicated all across this place. How will we do it?

Ms. **Branch**. Well, Congressman Espy, what we did with our particular program in order to get it funded, was use JTPA monies and social services block grant monies to put together that whole initiative. Foundation grants to local providers would also work. Under the JOBS Program and the guidelines with the Family Support Act, it will not allow us to duplicate, entrepreneurship type programs without penalizing the client during the business start-up phase. That is why waivers were necessary. We need to be able to offer such programs to move people to self-sufficiency without the barriers that the waivers temporarily remove.

Mr. **Espy**. These are the regulatory problems that you were talking about.

Ms. **Branch**. That is correct.

Mr. **Espy**. So we just need to waive some of them. We need to change that.

Ms. **Branch**. Right. If we could replicate that kind of program, I think that we would have a lot more success in our JOBS Program.

Mr. **Espy**. Again, that is at the federal level.

Ms. **Branch**. That is correct.

Mr. **Espy**. Well, we have got some work to do. We can take care of those definite recommendations.

Now, I am confused on how you do this child enforcement support stuff. And I want to congratulate you on what I have been seeing and hearing on television about publishing names and all of that. I think that even a boy can make a baby, but it takes a man to take care of a family. We need to keep that, and if you do not do it, they ought to garnish your wages. If you do not do it, you ought to go to jail. I believe that.

But, as I understand it, if you collect some money in AFDC support cases, $50 of it goes to the AFDC child and the rest of it goes to offset the amount that goes to the client from AFDC, which means the money comes to the state. Is that true?

Ms. BRANCH. If the parent was on AFDC during the time receiving benefits, then federal law requires that some of that money go back in to reimburse the state. Right.

Mr. ESPY. How does it balance out because sometimes it costs more money to find the father and enforce the support order than it would take to provide the AFDC support.

Ms. BRANCH. Well, Congressman Espy, I think what the goal is is to make fathers be responsible so that we will not have to take them to court and make them support their kids with this program. I think people understand now, especially with the 10 most wanted list that we have published, that people have been coming forth in droves to pay their back child support because they do not want their photo on the poster.

And I think with that, we could have more money to increase the benefits for the people that are truly needy and really do need that support. Because, as Ms. Brown said, who can live on $144 a month. The state, as you said, will not put up the additional money to even draw down additional federal monies that we could get. So we are going to have to find ways within the state where we can make parents take care of kids do that, so we can have the extra money to support those folks that really do not have another way of making it.

Mr. ESPY. Thank you, Mr. Chairman. For my part, I think you have done a great job.

Ms. BRANCH. Thank you. I appreciate it.

The CHAIRMAN. Bill?

Mr. EMERSON. Mr. Chairman, I do not have any questions, but I do want to say that I think this has been a particularly valuable hearing. We have held many hearings over a long period of time and this particular hearing really stands out. I want to thank you and our good staff on the Hunger Committee and Congressman Espy and his outstanding staff, both in Washington and here in Mississippi, for the way this has been put together and structured and implemented. It has all come together here at this hearing this afternoon and our field visits this morning in a very meaningful way.

In that regard, Mr. Chairman, I want to make what may be an unusual unanimous consent request. I want to ask unanimous consent that the transcript of this hearing be transmitted, together with an appropriate cover letter from you and from me and Congressman Espy, to the Nutrition Subcommittee of the Agriculture Committee, to the Human Resources Subcommittee of the Ways and Means Committee, and to the Integration and Empowerment Task Forces of the White House Policy Council.

They need to know all of this data that has been very well put together and presented by our witnesses here today. We have commenced discussions with them. As you know, we had a good hearing on integration and coordination of services a week ago Monday. I have subsequently met with the Integration and Empowerment Task Forces at the White House. I think we have got people thinking in this subject area in ways that maybe they have not thought of before. Because of the value of this hearing, I would like to transmit the transcript of this hearing to those entities so they can study it and see this data that has been put together in such a meaningful way here today.

The CHAIRMAN. I think that is a good suggestion. Let us do it.

Mr. EMERSON. That was a unanimous consent request.

The CHAIRMAN. Well, without objection.

Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman. I just want to congratulate Ms. Moore for her very compelling testimony, and I thank Ms. Branch, also. I just have one quick question. The SEID Program that you talked about, how is that funded?

Ms. BRANCH. Federal funding.

Mr. ENGEL. It is. Can you help me, Ms. Branch, in terms of the percentage of federal funding?

Ms. BRANCH. Well, the program was originally put together with Job Training Partnership Act funds and social services block grant monies and a few state dollars, but most of them are federal monies.

Mr. ENGEL. Thank you. I have further questions, but I will submit them in writing. I, too, Mr. Chairman, must say that this hearing was well worth the multitude of planes I had to take to get down here. It was very enlightening, and I think it certainly will help me in my perspective and help us all in our work in Washington. Thank you.

Mr. ESPY. Just one parting word, Mr. Chairman.

First of all, thank you again for coming and bringing the Select Committee here. I want to thank the staff because as Bill said, they did a great job. I could name them all, but you know them all, and we know the work that you did and the time that you took to do it.

I want to thank my staff, particularly Katherine Nordal and Sharon Longino for work that they put in to doing this.

And to the audience because nobody has talked to you today. Listen, you may be sitting out there thinking that this is just academic stuff. You have heard a lot of numbers, a lot of statistics, and I know sometimes your eyes glaze over. You think that we are coming in from Washington and we are speaking over you and not to you.

But the fact is, this is very necessary in the long process of getting things done because you cannot sit in Washington and really do much. You have to come down here first of all to see how things really are. Then when you stand on the Floor of the United States House of Representatives, our colleagues will be in the chamber listening to us or listening to us on T.V. from their offices.

They sit up in their seats and they take note when the Chairman of the Select Committee on Hunger can say I have been to Bolton, not that I have read about Bolton, but that I have been to Bolton, I have been to Flora, I have been to Canton, and I have seen the problems. They listen, and that is exactly what we need them to do, just to listen.

If they listen, you know, it is amazing how much easier it is to get your point across. So we have to come here and bring the committee here to have a transcript that we can take and submit to the various committees that Bill Emerson talked about because it then becomes their forum and you can talk about getting money to do the kinds of things to improve the quality of life for the folks whose lives need improving.

So whether you know it or not, and I know that you do know it, but you are sitting through something that I think is very, very valuable.

And then the children who were here earlier, it is important for them to have seen this, as well. If they did not get anything else out of this other than hearing a New York accent which they have never heard before, I think that that is valuable, as well, and seeing a committee chairman like this one sitting up here with a gavel in his hand. You know, people can talk, that is rare for them, and that is very good.

So I think it has been a very good hearing and I thank those who took time out to put it together.

Mayor, I want to thank you for allowing us to have use of your city and use of this great facility. We appreciate it. This is not an idle hearing. Something will be done based on our having been here. Thank you.

The CHAIRMAN. I just want to conclude the hearing. I want to thank the witnesses and I just want to say what my colleagues said. I want to say it, too, that all of you have been really great and informative. It has been helpful to us. We can go back to Washington with a little bit better understanding of what is happening down here.

Being down here for one day does not make us experts, but you have a good congressman here, and he helps us be experts on some of your problems.

We want to thank the staff of the Select Committee on Hunger. They, again, have served up a very good hearing. Mike, you and your staff have been wonderful. I must say that of all the hearings that we have held in the country and even overseas the way we travel, we have never been received better than we have in Bolton, Mississippi, honest to God.

We have never had a place that has been so neat and it has been kind of whitewashed and painted. You can still smell the paint. The floor has been finished and the water and everything has just been laid out. I mean, there is not a better hearing in Washington, D.C., than this. So you have made us feel very welcome. We are most proud, and we are going to do our best to try to help with some of the many concerns that you have talked about today.

This hearing is over. Thank you.

[Whereupon, at 3:42 p.m., the hearing was concluded.]

[Material submitted for inclusion in the record follows:]

06-04-91 06:29 AM FROM US REP MIKE ESPY

5-2-91

MCES

MISSISSIPPI COOPERATIVE EXTENSION SERVICE

Mississippi State University, United States Department of Agriculture, Counties Cooperating

P. O. Box 915
Greenville, MS 38701

May 28, 1991

Congressman Mike Espy
U. S. House of Representatives
Select Committee on Hunger
Room H2-505, Ford House Office Building
Washington, DC 20515-6408

Dear Mr. Espy,

As per your letter of May 10, 1991, concerning my testifying at our May 3rd hearing in Bolton, Mississippi, I am enclosing answers to the questions submitted to me by Representative Engel.

Question #1 - What kinds of improvements do you see in the food buying and preparation habits of people who have completed your nutrition education courses?

The improvements in food buying involve the use of coupons, the use of ads in newspapers, the reading of food labels, and comparative shopping by comparing name brands to generic brands. The preparation habits of the people I am involved with are as follows: 1. I teach people to bake, broil or barbeque foods as opposed to frying. 2. I advise them to use other seasonings besides salt in preparation. 3. I advise my clients to cook foods ahead of time and freeze them or to cook large quantities and freeze them. With these improvements in food buying and preparation habits, I feel my clients are getting a nutritious diet for less money and are able to use various ways of cooking and seasoning foods.

Question #2 - I have seen research that low-income families in rural areas have very limited access to fresh fruits, vegetables and meats. What kind of counseling and services do you provide to compensate for this shortage?

I work in rural areas - Hollandale, Arcola, and Glen Allen, MS. People in these areas still have small gardens. They have access to fresh fruits, vegetables and meats. During the summer months, I advise my clients to freeze or can these fresh fruits and vegetables. Also, in the summer months, vendors have fresh fruits and vegetables to sell. Meats are available year round. I tell my clients to buy fruits and vegetables by the season to save money. We know that during the summer, they are cheaper. I also provide recipes or any information they need in order to prepare or preserve these foods.

I hope this information is of help to you.

Sincerely,

Viola Hudson

Viola Hudson,
EFNEP EDUCATOR

TONY P. HALL
CHAIRMAN

Select Committee on Hunger
U.S. House of Representatives
H2-505 House Office Building Annex 2
Washington, D.C. 20515

news release

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Opening Statement

Congressman Tony P. Hall, Chairman

May 3, 1991

Good Afternoon. I am Tony Hall and I am the Chairman of the House Select Committee on Hunger. I want to thank all of you for coming out to join us this afternoon. The Committee is here today at the request of the Chairman of our Task Force on Domestic Hunger, Congressman Mike Espy. We are all honored to be here and thankful to Mike for giving us this opportunity to examine how Federal assistance programs are doing in the fight to end hunger and poverty here in the Delta. If you know Mike Espy, you know how committed and persistent he is. The fact that he has brought us to Bolton today, shows how concerned he is about what is happening here. Mike wants to educate the Committee and his other colleagues in the Congress about what steps we need to take to wipe out poverty and hunger in the Delta.

When the Committee was last in Mississippi, in 1987, over 25 percent of the population lived in poverty, the unemployment rate stood at 11.7 percent, and 14 of every thousand babies born died before their first birthday. These statistics were all higher than the national figures. Since then, the Congress approved the Family Support Act of 1988 to provide new opportunities for job training and employment. We passed the Hunger Prevention Act of 1988 to improve the Food Stamp and commodity distribution programs. We reauthorized the WIC and other child nutrition programs to strengthen the health and nutrition of pregnant women, infants and young children. We expanded housing assistance and economic development programs, and we approved an increase in the minimum wage.

This is a pretty comprehensive list of accomplishments. But it is a list of empty accomplishments if all of these programs are not successful in making sure that people have enough to eat without facing bureaucratic hurdles at every turn. They are empty if people in the Delta have to live in substandard housing. They are empty if babies continue to die because their mothers don't get proper food and health care during pregnancy. And they are empty if the welfare system perpetuates poverty instead of supporting and encouraging economic self-sufficiency.

Our witnesses this afternoon are going to tell us how far all of these accomplishments have moved us towards the goal of improving the quality of life here in Mississippi and how far we have yet to go. I look forward to an enlightening hearing.

OPENING STATEMENT OF HON. MIKE ESPY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Thank you, Mr. Chairman, and welcome to the 2nd district of Mississippi. I would also like to welcome other members of the Select Committee on Hunger --Mr. Bill Emerson, ranking minority member and Representative from Missouri, and; Mr. Eliot Engel, Representative from New York.

We would also like to thank all of the citizens of Mississippi who have turned out today for this hearing, in support of efforts to aid those affected by poverty and hunger.

A special thanks goes to our witnesses today. We appreciate all of you. And we recognize that you have interrupted your very busy schedules to come and speak to the issues of poverty and hunger. We look forward to your testimony--it is always good to hear from real-world, front-line providers and consumers of these services. We hope to gain from you some real-world, practical information which we can use to make our programs more effective and efficient.

This is the Select Committee's third trip to Mississippi. The first one was in 1984, before I entered Congress. In 1987, we came to Mississippi again. That was a special trip, under the leadership of Mickey Leland, Representative from Texas. Congressman Leland, who was so committed to improving the lives of the poor and the hungry, lost his life in a plane crash in Africa in August of 1989, two years after that hearing.

Congressman Tony Hall, our current chairman, has continued the Committee's effort to address hunger both at home and abroad.

Today, we are back in Mississippi. We have basically two main items on our hearing agenda this afternoon. We want to look at the poverty-related hunger and nutritional status of our citizens, particularly our vulnerable children and older Americans. And we want to examine how well, or maybe not so well, our programs in these areas are addressing the needs of our citizens. We also want to look at recent welfare reform efforts designed to promote economic self-sufficiency and reduce dependency on public assistance programs.

Although our nation overall has been a prosperous one, far too many Americans live on the fringes of that prosperity. During the past decade, we have made virtually no progress in reducing the national poverty rate among the non-elderly population. The same can be said for Mississippi:

1. In our state of approximately 2.57 million persons, 25.8%, or about 664,000 of our citizens live in poverty. While the poverty rate of our white population is 11%, the poverty rate of black Mississippians is a staggering 48.6%, or 444,718 people. More than one-third of our children live in poverty. Sadly, these rates are not significantly different from those found in Mississippi a decade ago.

2. The number of families participating in the Food Stamp Program in Mississippi has increased since our last hearing from 159,714 to 186,688.

3. Our Aid to Families with Dependent Children (AFDC) has increased some 10% since 1987, up from 53,685 to 59,095 families. Those 59,095 families comprise 22% of our state's population.

4. Our per capita income of $8088 in 1987, while up from $5183 in 1979, is only 67% of the national average.

5. Our teen pregnancy rate is still one of the highest in the nation. Of the 43,026 live births in 1989, 21.5% were to teen mothers. And, 73% of those teen mothers were unmarried.

6. During 1989, 68% of infants born in Mississippi qualified for the WIC program. This figure confirms that a still unacceptable number of infants in Mississippi are born into poverty. During 1990, the WIC program served 102,226 women, infants, and children. WIC has grown substantially, serving 12,269 more individuals in 1990 than it did in 1987.

7. Although our unemployment rate has dropped significantly, with a current statewide rate of 8.0% as compared with 13.8% four years ago, there are still some counties in the 2nd district with rates as high as 26%.

But, there has also been some progress in Mississippi:

1. Our high school graduation rate, currently at 66.9%, has increased as has the number of heads of household with high school diplomas.

2. Our infant mortality rate has dropped significantly from 17.9 deaths/1000 births in 1979 to 11.6 deaths/1000 births in 1989.

3. Our number of babies with low birth weight has also improved, but not as dramatically as the infant mortality rates. The 1989 rate was 9.4% statewide, with a rate of 6.5% for white babies, and 12.4% for black babies.

4. The median family income for a family of four rose from $17,672 in 1979 to $32,300 in 1989.

5. And, we have dramatically increased our nutritional support to the elderly through the congregate and home-delivered meals programs. In 1986, we served 12,370 clients per day, and currently we are serving 19,848 clients daily.

We have made progress in Mississippi, but there is still a lot to be done. We currently have 75 federal programs providing assistance in the form of medical care, cash aid, food aid, housing assistance, education assistance, jobs training, and energy assistance to low-income individuals. The combined federal and state funding for these programs exceeds $173 billion annually. Although the price of helping those in need can be high, even higher is the price of neglect.

History has shown us that government's merely throwing money in a haphazard, patchwork, bandaid fashion at the problems of the poor does not solve the problems of poverty. We need new and innovative systems to address these old, pervasive, and persistent problems. Economic, demographic, and social conditions have changed since our social welfare system was developed in the 1930's; but, our social policies have not adapted to these changes.

During the 1970's and 1980's, a growing perception of failure in our social welfare programs became widespread. Concern over the financial, social, and moral costs of dependency led some to claim that government programs were not only not solving the problem, they were becoming a large part of the problem.

While America has grown skeptical of programs that foster dependency, it has also learned that it is futile to ask people to take greater personal responsibility for their lives unless they have a real chance to escape from the material conditions that foster insecurity and despair. The best policy for promoting human welfare, or well-being, is one that offers individuals both economic opportunity and social protection. Self-reliance should be encouraged but it will be most effective within the context of a supportive social framework. While work is fundamental to welfare reform, people often need assistance in preparing for work as well as some basic support while they are working. A family is better off psychologically and socially when it earns enough to pay its own way.

Since the Select Committee was in Mississippi in 1987, there have been some changes in our thinking about our social welfare programs. The Family Support Act of 1988 was designed to promote income self-sufficiency, eliminate long-term dependency on public assistance, and promote the involvement of both parents, whether living together or not, in supporting their children.

Today, we want to look at Mississippi's efforts in implementing The Family Support Act and hear from our witnesses about the future prospects of the poor under this new program. We also will hear testimony about our domestic food assistance programs and how they are impacting the nutritional status of their recipients. The testimony regarding the nutritional status and needs of older Americans is particularly timely, since the Older Americans Act is scheduled for reauthorization this year.

I look forward to hearing from our panel of distinguished witnesses this afternoon. I trust they will provide us with useful information that can be translated into more effective public policy.

END

Remarks of Congressman Bill Emerson
for the Select Committee on Hunger
Bolton, Missiissippi Hearing May 3, 1991

I am really happy to be here today with Congressman Tony Hall who is Chairman of the House Select Committee on Hunger and with your Congressman Mike Espy. Mike and Tony and I have been working together for some years now on our national programs which help our people gain improved access to food, medical care, education and housing.

In 1984 I came to your part of our country for the very first field hearing held by the Hunger Committee. I represent the 8th District in Missouri, just up the Mississippi River and a part of the Lower Delta Mississippi Region. It is really good to be back with all of you today and I certainly look forward to hearing the testimony of all the witnesses and to learning what you propose.

Today, six years later, the Hunger Committee returns to Mississippi because we know you good people are coping with a complexity of public assistance issues which are difficult to resolve but whose root cause is the lack of enough good job opportunities within the region. I look forward to hearing the way you have creatively brought about innovative improvements...and I look forward to learning what we in Congress may be able to do to help foster a better environment for life and work.

help foster a better environment for life and work.

When a family unit is in need of help, I understand that their needs often reach into several areas. When a family needs income assistance it often means that family also needs help in food supplies, in housing, and help in finding and keeping a good job. If we are able to bring together , to co-ordinate assistance in several areas we have a good chance of preparing that family for re-entry into the work force and for regaining their self-sufficiency ...and their self-respect. On the other hand, if that family only receives minimal and disjointed assistance it often means it will be able to eke out only a survival level of existence ...and probably be unable to ever break out of the welfare cycle. To reduce long term dependency on public assistance we must first provide short term assistance which is powerful, which gives "the biggest bang for our buck" so that people can again become responsible for themselves.

For some years now I have been meeting with folks to talk about what I think is the best way to get real effectiveness from our welfare programs. Do you know there are 125 different public assistance programs? Since 1964 this country has spent two trillion dollars on our public assistance. But have we gotten from all this money and all these programs the very best possible results. You and I both don't think so. Most often the assistance has been fragmented, it has only addressed part of a family's problem rather than removing the root causes. I think a concept I like to call One Stop Shopping is a powerful way of helping a family or individual receive a co-ordinated package of assistance which it or he or she can use to establish a strong economic, health, and social base in order to be equipped to be a strong student, a strong member of the workforce, a strong, nurturing parent, a productive member of the community and country. I have found the States are committed to this approach because they are on the front lines struggling with the problems of providing meaningful assistance to a growing number of persons from a shrinking pie.

Very often people will say, "Oh, but that approach sure sounds expensive." I don't know that. Not if it gets people out to work, not if it promotes programs under unified application forms and consolidates programs within central locations, not if it helps to teach young mothers-to-be to get out to their doctors for early prenatal care, not if it helps to make available nutritional training to mothers so their children enter the classrooms physically able to learn, not if it helps provide skill- training so our young people can enjoy career development.

We have to support the thinking which says that in order for our Nation to continue as a leader, all her people must be strong and fully involved in national achievement. Our people are one of our greatest national assests -- all of our people, not merely the fortunate segments.

I've just returned from the Persian Gulf where I witnessed with great pleasure the valuable results of American commitment to finding the wherewithal of defeating Saddam Hussein. Time and again we were shown examples of how our commitment to win was aided by what has come to be known as "American Ingenuity." Maybe we are at a crossroads in our public assistance thinking - maybe we need to provide our states with increased flexibility to implement such things as One Stop Shopping concepts, to apply their local ingenuity to develop solutions which best answer their specific local problems. We can help you best when we understand your needs and ideas. Let us know how we can help in developing and coordinating programs that get results. Give us your ideas. That is what we are here to learn.

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

Reply To:

Alton B. Cobb, M.D., M.P.H.
State Health Officer

P.O. Box 1700/2423 North State Street/Jackson, Mississippi 39215-1700/(601)960-7400

May 30, 1991

Tony Hall, Chair
Mike Espy, Chair, DTF
U.S. House of Representatives
Select Committee on Hunger
Room H2-505
Ford House Office Building
Washington, D.C. 20515-6408

Dear Sirs:

Enclosed find my response to the questions posed to me. Thank you for the opportunity for input. If you have any further questions, please feel free to contact me.

Sincerely,

Agnes W Hinton

Agnes W. Hinton, R.D., M.S.
Director, Nutrition Services

QUESTION:

What would be necessary to expand the Perinatal High Risk Program into all counties?

ANSWER:

Legislative authority already exists to expand the Perinatal High Risk Program (PHRM) into all counties. We need positions authorized by the State Personnel Board to hire additional nurses, social workers, and nutritionists, and we need dollars to provide the state match for Medicaid or to provide start-up funds for staff until they can generate enough earnings to fund their salaries (usually 3 to 6 months). The Governor's Infant Mortality Task Force in their 1991 Report to the Governor state that full implementation and utilization will require a maximum program cost of $10 million. Only $2 million of that amount is required from state funds, to provide the Medicaid match.

Additionally, salaries for nutritionists, social workers, and nurses must be somewhat competitive with the private market to be able to recruit and retain qualified staff. In some cases additional office space is needed to house teams.

FOLLOW-UP: How does this program tie in with the perinatal regionalization program?

The Perinatal Regionalization Program encourages communication and patient referral between health department clinics, community health centers, private physicians and Level I, II, and III hospitals. Perinatal Regionalization (PR) staff encourage private provider participation in PHRM and assist PHRM staff in communicating with the appropriate hospital staff. Perinatal Regionalization focuses on improving the system of care, while PHRM is more focused on individual clients.

QUESTION:

A 1990 study by Public Voice for Food and Health Policy reported that the availability of fresh fruits, vegetables, and meats is extremely limited in low income rural areas. What steps are being taken to improve the access to these types of foods here in isolated rural communities?

ANSWER:

I am not aware of any efforts currently underway. An Extension Agriculture Specialist is attempting to begin a regional farmers market project, but adequate support has not yet been found. This is truly an area of concern, but it will require additional resources to address.

QUESTION:

What specific steps would you recommend for establishing a system for improving data collection in the nutrition status of low-income Mississippians?

ANSWER:

Our current Pediatric Nutrition Surveillance System, which now includes only WIC applicants, should be expanded to include all those screened in EPSDT as well as those participating in Headstart programs.

All women (including teens) participating in MSDH Family Planning Programs should be included in nutrition surveillance for overweight, underweight and anemia.

Day care centers and kindergartens could be required to see proof of an physical examination, which could be done at a health department, community health center, or private physician's office, and which should include a height, weight, and hematocrit or hemoglobin. Children below the fifth percentile could be referred to a school nurse or a nutritionist with a health center.

Additionally, all hospital emergency rooms should be required to measure height as well as weight, with referral of severely underweight children to a nutritionist.

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FOOD AND NUTRITION NEEDS OF MISSISSIPPIANS

Statement to the House Select Committee on Hunger Hearing
Bolton, Mississippi
May 3, 1991

Agnes W. Hinton, RD, MS
Director, Nutrition Services
Mississippi State Department of Health

Thank you for the opportunity to address you. I'd like to speak to four issues: 1) food and nutrition needs of low income Mississippians, with emphasis on children and the elderly, 2) the adequacy of current programs to meet needs, 3) recommendations to improve program participation and service quality, 4) progress since the 1987 hearing.

First I'd like to address the known and unknowns regarding the nutritional status of Mississippians. The State Department of Health operates two nutrition surveillance systems through our WIC program for the pediatric and pregnant populations. We've also conducted a special study regarding surveillance of severe pediatric undernutrition.

Our Pediatric Nutrition Surveillance System 1989 data again confirms the higher nutrition risk of children on WIC. Prevalence rates exceed the expected norms for children of similar age for shortness, overweight, and low hematocrit. Low birth weight is more prevalent and breastfeeding less prevalent than expected norms. Prevalence rates for almost all values, however, have shown significant improvements over the last few years. This again shows the importance of full funding for WIC, the need for funds targeted to breastfeeding promotion, and the need for WIC to be closely integrated with health programs such as Maternal and Child Health and Medicaid.

The Pregnancy Nutrition Surveillance System 1989 data showed a significant prevalence of risk of iron deficiency anemia, obesity, underweight, and a problem with both low and high birth weight infants. Smoking and alcohol behavior before, during and after pregnancy is also reflected through the system. These data underscore the importance of WIC both during the prenatal and postpartum periods - both times of tremendous opportunity for health education and health service provision which can result in improved maternal and infant outcomes.

The Surveillance of Severe Pediatric Undernutrition Project, funded by CDC, initiated surveillance activity in Health District III, the Mississippi Delta, during 1988 - 1990 and in Health District V (Hinds and surrounding counties) during 1989-90. The project was to investigate the prevalence and cause of severe pediatric undernutrition among children 6 months to 6 years of age. Our study found a prevalence rate of 2.31/10,000 population of cases meeting the SSPUN definition (primarily severely underweight or anemic children), or 192 children, with 104 from the Delta area. The greatest risk factors from SSPUN were income below 100% of the poverty level, a mother 41 to 50 years of age, and being nonwhite. Other risk factors included chronic disease (41%), either low birth weight or prematurity (27%), recent hospitalization (24%), and social factors such as a young or undereducated mother and a number of preschool siblings (11%). Only 5% of the cases were classified as due to inadequate food calories, 3% to abuse neglect and 2% due to nonparticipation in social programs. However, it should be noted that we did not do door-to-door surveillance, although referral to the program was promoted among all community health providers and all age-appropriate pediatric inpatients at the state's only tertiary level center were included in surveillance. The SSPUN pilot showed us that even participation in programs such as WIC (166 of the 192 children were in WIC) did not preclude these children's needing more intensive follow up and support for improved health outcomes.

Very little state specific nutrition is available for any other population group in the state, including the elderly, another high nutrition risk group.

The Department of Health does conduct Behavioral Risk Factor Surveillance as designed by CDC which is based on the results of telephone surveys to randomly selected residents age 18 or over. The low income population is likely under-represented as only those with telephones are contacted. 1988 survey data includes 12.9% respondents 55-64 years and 15.3% of respondents 65 years and over. Risk factors in the survey included hypertension, obesity, and sedentary lifestyle. 27% of the 1988 respondents reported having been told their blood pressure was high, with 47% of persons over 65 years reporting hypertension. Hypertensives were three times as likely to report household income below $15,000 and twice as likely to have less than a high school education. While the reported prevalence of obesity was highest among 35-44 year olds, over 30% of those 55-64 and over 25% of those 65 plus reported being obese and trying to lose weight. Sedentary lifestyles were reported by over 40% of those 55-64 and over 50% of those 65 plus.

While all this data is significant, we must also recognize how much we don't know about the nutritional status of Mississippians. Other than the WIC Program, no health programs currently routinely report participant nutrition status data. For example, while both Headstart and EPSDT Programs have a strong individualized health component, there is no aggregate data regarding basic nutrition measures such as weight or iron status of program participants. If all existing federally funded health programs for children were mandated to capture and report basic nutrition surveillance information, we would have a much clearer picture of the health status of many of our most at-risk children - and we could do so without initiating costly and time consuming special studies.

Next, I'll address the adequacy of present programs to meet food and nutrition needs in our state.

The WIC Program currently serves 68% of the state's potentially eligible population, with an even higher percentage of infants being served. In FY90, 70% of the babies born in the state were on the WIC Program, close to 100% of the potentially eligible infants. While we support the need for full funding of WIC to serve all eligible participants in all categories, we also recognize that WIC dollars cannot adequately support the health services infrastructure needed for the programs's maximum effectiveness. Increases in funds for MCH Block grant and primary care funds are also needed to assure the availability of quality perinatal and child health services.

The school lunch program in Mississippi currently serves around 77% of all enrolled children. The greatest problem with our program is inadequate funding to provide quality foods which support the U. S. dietary guidelines. I support he recommendation that an additional five cents/meal be allocated to provide adequate resources for schools for improved food quality. Our school breakfast program serves about 2/3's less children than those served at lunch. We need a state mandate that school breakfast be offered in all schools.

The Expanded Food and Nutrition Education Program of the Cooperative Extension Services, currently operates in about 32 of Mississippi's 82 counties. You'll hear next about an innovative marriage of WIC and EFNEP operating in the Mississippi Delta. This program should be available in all counties and this will require an increase in federal funding for EFNEP.

An estimated 30% of Mississippi's elderly live below the federal poverty levels, yet less than 1% are currently served by our congregate or home delivered meals programs - an imperative for increased funding. Additionally, all state agencies on aging should have nutrition professionals on a full or part time basis to assist in administering elderly feeding programs. A federal mandate to that effect would greatly strengthen both the food service and education components of elderly feeding programs. Additionally, I encourage congress to look at innovative ways for existing programs to work together. A coalition of the Council on Aging, the WIC Program, and the Extension Program could deliver supplemental foods and nutrition education to the elderly for example. While such a program would require additional funds, utilizing existing programs could reduce program costs and minimize start-up time.

And finally, the benefit levels under the Food Stamp Program need to be increased to meet the cost of USDA's Moderate Food Plan. Participation barriers such as complex application procedures need to be reduced, and nutrition education should be offered as a component of the Food Stamp Program.

As to recommendations to improve program participation and service quality I offer the following:

Health care services need to be better triaged. For example, all those eligible for WIC are at some level of nutrition risk and need basic services. However, those at highest risk need intensive intervention, with multidisciplinary case management, home visiting, and health education. By tailoring the intensity of services delivered to the client's needs, scarce manpower resources can be best utilized to improve health outcomes.

Some programs need to be better coordinated or integrated. States should be rewarded for innovative programming that meets client needs rather than merely following program guidelines.

A real barrier to quality service delivery currently is adequate staff to provide the level of needed services. Impeding factors include low salaries which hinder recruitment and retention of the best qualified staff, a lack of physical facilities to house expanded services, and adequate funding for programs.

An additional barrier is the low priority preventive health services received from consumers, program administrators, and legislators. Too much of our health care dollar is spent in curing severe problems, and too little in problem prevention. Increased funding for preventive services including health education from K-12 and in professional health related training is needed.

Now to address progress since the 1987 hearing. We've seen funding increased for WIC, food stamps, and school feeding programs. The National Nutrition Monitoring Bill was passed and CDC has allocated funds for Nutrition Surveillance. The Partners for Improved Nutrition and Health Project, PINAH, is making progress in six Delta counties. Medicaid expansions helped establish Mississippi's Perinatal High Risk management/Infant Services System, which is providing interdisciplinary case management, home visiting and health education, all with a strong nutrition component,in 1/3 of Mississippi's counties. We've added nutrition modules to our BRFS Survey in 1990 and 91 which will enhance our knowledge of the state's adult's nutrition status.

I know members of this committee have been instrumental in accomplishing much of this. Thank you for the commitment and concern you've exhibited. I'd only ask that you continue to persevere to assist us in solving the state's many food and nutrition related health problems.

MISSISSIPPI HUMAN SERVICES COALITION

921 N. Congress
Jackson, MS 39202
(601)355-7495

SELECT COMMITTEE ON HUNGER
FIELD HEARING: Bolton, MS, May 3, 1991

Thank you for inviting me once again to speak with you about the conditions of hungry people in Mississippi and the programs designed to serve them. I still vividly recall this committee's last visit and the inspiration that came from spending a day with the late Congressman Mickey Leland. This testimony is dedicated to Mickey and to those poor people who still must struggle day by day to survive.

Currently, just over 188,000 households rely on Food Stamps for their nutritional needs, a 12% increase since your committee was last hear in 1987 (and a similar increase since our peak unemployment in the early 1980s). The employment opportunities in Mississippi are not sufficient to enable families to pull themselves up high enough to reach a level of self-sufficiency. Many of our people have only been able to find marginal jobs which leave them below the poverty line. Without sufficient job opportunities, our people will always be dependent upon assistance to survive.

Another factor is that our service delivery system is working at capacity. The caseload per worker has risen in the last two years from 307 cases to 353 cases. Due to the state's fiscal condition, the Department of Human Services is operating under severe constraints, leaving many county offices shorthanded and many workers with inadequate training to meet the needs of the applicant citizenry. In addition to processing the applications for Food Stamps and AFDC, these workers now have additional duties to perform relating to Medical Assistance (Medicaid), Child Support, and JOBS. The workers become stressed out, leaving the clients served in a less than timely manner. In this county twenty percent of the families do not have their eligibility determined within the federally established timelines.

There are some private efforts to feed the hungry. The Mississippi Food Network (the state-wide food bank) has seen an increase in demand of 15%

for the first Quarter of 1991 over the same period in 1990. Each month another eight to twelve food pantries join this network of hunger relief agencies, enabling greater coverage of the state. This charity is, however, no substitute for government responsibility. We must have a policy that no one will go hungry in this country, and that the government will insure that every person will have certain basic needs met.

Under the Family Support Act, Mississippi initiated the AFDC-Unemployed Parent program last October. Since that time only 112 families have been certified as eligible. This represents only one of every 785 unemployed persons in our state. In six months we have failed to reach the needy families that fit into this category. There is a great need for outreach to insure that families in need of assistance know that they are eligible and are able to apply for and receive services.

The state also implemented the JOBS program, but attempted to do this with the minimum financial commitment. As a result, the services to clients who would like to end their dependency on welfare are minimal and families are left with requirements to cooperate without getting much in return for their effort. Many persons assigned to JOBS participation got child care vouchers and a public bus pass, and were told to go look for a job. As a member of the Hinds County JOBS program Coordinating Council I am concerned that we do not have the resources to offer the clients hope and a program that would enable them to develop their natural abilities so that they could embark on fulfilling careers.

We have made some important gains in Mississippi. With a solid commitment of energy and resources, we have made important improvements in reducing Infant Mortality. When the first Hunger Study was done by the Field Foundation, the rate was 35.3 per 1,000 live births; at your last visit the rate was 13.7; in 1989 it was 11.7; and today it is still dropping. We have a long way to go, but we have the political will to get there. The major impediment is the high poverty rate that impacts on infant mortality and all other measures of quality of life.

In closing, I would place at the top of our needs list:

1. Meaningful jobs and economic activity;
2. Creative and realistic education and training programs;
3. Adequate staffing for programs impacting hunger;
4. An increased commitment to improve the Food Stamp program.

TESTIMONY FOR THE HOUSE SELECT COMMITTEE ON HUNGER
MS. VIOLA HUDSON, HOLLANDALE, MISSISSIPPI
MAY 3, 1991

1. Good afternoon. I am Viola Hudson from Hollandale, MS . I am the mother of 7 children. I am a member of the First Baptist Church of Hollandale, MS. I am a sponsor for the Jog-A-Thon for Novata High School Track and Field. And I give donations to different charities: cancer, heart, leukemia. My family participates in the school lunch program and the food stamp program.

2. I am a EFNEP Educator with the Mississippi Cooperative Extension Service. I have worked as a Nutrition Educator program assistant for two years and two months as of today. EFNEP stands for Expanded Food and Nutrition Education Program. EFNEP is now working in partnership with the Health Department's WIC program and Partners for Improved Nutrition and Health, better known as PINAH.

For over twenty years the Cooperative Extension Service has offered nutrition education nationally through a home visitation program to low income families. In 1988, the Mississippi Cooperative Extension Service, the State Health Department, and the Freedom From Hunger Foundation formed a partnership called PINAH - Partners for Improved Nutrition and Health - and through PINAH the Partners for Life project was developed.

Last fall, the Partners for Life project came to our county and we have been working in Washington County, Mississippi to deliver this program to our clients. We know you have the numbers about infant mortality and low birth weight babies. Over the past five years, more than 87 babies died in our county before the age of 1 year. In 1989, about 137 babies were born with low birth weight: this means the babies weighed less than 5 and 1/2 pounds at birth. Low birth weight means higher mortality and learning disabilities.

The Mississippi Cooperative Extension Service is trying to combat these problems, but they cannot do it alone. That is why we need your support so that we can have more healthy babies instead of low birth weight babies.

3. We have trained local program assistants in nutrition, maternal and child health, and parenting. They are known as EFNEP Educators. When a WIC client meets with Educator she can learn how dieting affects her baby's health and happiness, and what to expect during her pregnancy and childbirth. She will learn how to care for her newborn child, and why breastfeeding is so important for her and the baby. She will learn where to go for community resources, and we also show her how to get information that we do not know of. The information that we received from our training is carried back to the community to share with our clients in a one-to-one setting, or with two or three other clients or friends, or family members, or with a small group. Which ever way is comfortable with clients. You can't just pick up your setting.

Out of these lessons you get more educated and wiser of life , and comfortable in knowing what they are doing before the birth and after the birth of their child. I have learned a whole lot in educating my clients and also myself. I have learned how to communicate with them in their setting of life. And how to give them understanding, caring, and support whenever it's needed without regrets.

4. I have 36 clients that I am now working with, and most of them are teenagers. We get the majority of our clients through the Health Department, some in the community, -- others through conversation with my clients' friends, and also through WIC if they are eligible. They are referred by their family, by someone I have already enrolled sometimes, or even by their own mother.

One of the main things we as EFNEP Educators stress to our new mothers is to keep all of their doctor or clinic appointments. We tell them to get all of their required servings of milk, to eat a variety of food to get all of the nutrients they need, and to get 4 servings daily of fruit and vegetables to feel fine. We encourage them to exercise, we tell them about danger signs, to avoid alcohol and drugs, and how to control fatigue and stress, and how important it is to gain the right amount of weight.

There are 24 other Educators in 5 Delta Counties in the Partners for Life EFNEP program. We think Congress ought to expand the EFNEP program so that any woman can have this support during her pregnancy - and have a healthy baby. I hope that once you have heard what I have said you have a clear heart and understanding that we need your support 100%. You could really make life and society better not only for this generation but the generations to come.

Thank you very much!

Hello, My name is Carolyn Moore and I am here to testify before the House Select Committee on Hunger.

I was on welfare for a year. I never thought that I would ever be on welfare. I was the only one of my six brothers and sisters to be on welfare and to not finish school.

After a divorce from an abusive marriage, I went to the welfare office to get child support but ended up getting AFDC.

I started looking for ways to get off welfare, but jobs were hard to find. One day I found a letter on my door about a project that would help you get off welfare by starting a business. I kept the letter for about a week because I just did not believe it could be true. Finally, I went to the orientation and learned more about the program. I also felt that the program was true because it was sponsored by Friends of Children of Ms. Inc., I am a Head Start parent and I know Head Start is a name you can trust.

When I enrolled in the program, I didn't realize how low my self-esteem was. Having no job, being on welfare, not knowing how I would take care of three boys made me feel real low. The program helped me feel good about myself and helped me realize that I could get off welfare I learned to do marketing research through the rogram. I knew there was a need for janitorial service, but I didn't know how to start one.

People have skills and talent, though they may not have the education, they can still do productive things with programs like SEID. Now I have gone from welfare to entrepreneurship. I received a loan through the SEID program to start my janitorial service and I am grossing about $1500 a month.

Don't ever feel that you can't do anything or any better. You've got to first want to help yourself. There will be people who try to discourage you when they're in the same boat as you, just like the people who talked down about the SEID program. You have to see far yourself because it is your future. Welfare and food stamps may not always be around, but the children will be, and you have to feed them. There should be more programs like SIED to give people an opportunity to help themselves, feel good about themselves and make their own money.

MISSISSIPPI REVISITED: POVERTY AND HUNGER – PROBLEMS AND PROSPECTS FACT SHEET

Population Distribution for Mississippi by Race and Hispanic Origin, 1990[1]**:**

	Number	Percent
Total Population	2,573,216	100.0
White	1,633,461	63.5
Black	915,057	35.6
American Indian, Eskimo, or Aleut	8,525	0.3
Asian or Pacific Islander	13,016	0.5
Other Race	3,157	0.1
Hispanic Origin	15,931	0.6

In 1989, the population of Mississippi was 2,575,514. Roughly 1/4 of the population (25.4%) of Mississippi was living below the poverty line in 1989.

DEMOGRAPHIC DATA						
	Mississippi			United States		
	Total	Black	White	Total	Black	White
High School Graduation Rate[2]	66.9	N/A	N/A	75.8	63.4	77.3
Poverty Rate	25.8	48.6	11.4	12.8	30.7	10
Unemployment Rate	8.0	15.9	4.1	5.3	11.4	4.5
Per Capita Income[3]	$8,088	N/A	N/A	$11,923	N/A	N/A

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[1] 1990 data from the U.S. Census Bureau, 1991.

[2] The Average educational attainment of heads of households in Mississippi from 1986-1988 is as follows: 21% had 0-8 years of schooling and 16% had 9-11 years of schooling, leaving a total of 37% without their high school diplomas. Source: The Center on Budget and Policy Priorities, March 1991.

[3] 1988 data taken from the U.S. Census Bureau, Statistical Abstract of the United States, 1990.

EMPLOYMENT DATA, DECEMBER 1990[4]

	Second District	Mississippi
Civilian Labor Force	201,000	1,191,700
Total Unemployed	22,400	95,700
Unemployment Rate	11.1%	8.0%
Total Employed	178,600	1,096,000

Note: The U.S. Unemployment Rate was 5.4 percent for that same period.

1990 POVERTY LINE FIGURES[5]

Size of the family unit	Poverty guideline
1	$6,620
2	$8,880
3	$11,140
4	$13,400
5	$15,660
6	$17,920
7	$20,180
8	$22,440

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[4] Mississippi Employment Security Commission, February 1991.

[5] 1989 Poverty income guidelines for all states (except Alaska and Hawaii) and the District of Columbia. For family units with more than 8 members, add $2,260 for each additional member.

CHILDREN: A REPORT CARD[6]

	Mississippi	U.S.
Early Prenatal Care (percent of all live births with early prenatal care in 1987)	76.5	76.0
Teen Birth Rate (Births to females ages 15-19 per 1,000 women of those ages in 1986)	73.7	50.6
Births to Unmarried Women (percent of births that were to unmarried mothers in 1987)	35.1	24.5
Paternities Established (paternities established per 1,000 births to unmarried women in 1987)	126.9	273.0
Children in Poverty (percent of children under 18 who were poor in 1985)	34.3	20.9

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[6] Children 1990, A Report Card, Briefing Book, and Action Primer, Children's Defense Fund.

INFANT MORTALITY AND LOW BIRTH WEIGHT[7]

In 1988, the infant mortality rate in Mississippi was 12.3 per 1,000 live births, and the infant mortality rate for the U.S. was 10.0 per 1,000 live births.

In 1988, 3,668 low birth weight babies were born in MS. out of 42,074 live births (8.72%). Nationwide, 270,681 low birth weight babies born out of 3,909,510 live births (6.9%).

AFDC PROGRAM DATA[8]
for a One-Parent Family of Four Persons

	Mississippi	Median State
Need Standard	$433	$432
Gross Income Limit (185% of need standard)	$801.05	$799.20
Maximum AFDC Benefit	$144	$432
Maximum Food Stamp Benefit	$331	$288
Combined Benefits	$475	$720
Combined benefits as a % of 1989 poverty threshold	45%	**68.2%**

JANUARY 1991 AFDC PARTICIPATION DATA FOR MISSISSIPPI[9]

Total number of households participating	59,095
Total number of people participating	174,651 (22% of population)
Total number of Dependent Children participating	125,967
Total number of AFDC-UP cases	80 (370 people)

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[7] National Center for Health Statistics, 1988.

[8] CRS Report for Congress, Aid To Families With Dependent Children: Need Standards, Payment Standards, and Maximum Benefits for Families with No Countable Income, Carmen Solomon, November 1990.

[9] Mississippi Department of Human Services, 1991.

STATISTICS ON CHILD SUPPORT ENFORCEMENT (CSE)[10]

In 1989 there were 425,674 children in Mississippi who were entitled to child support. Only 27% of these are cases with collections.

Child support caseload in Mississippi is 750 per worker. The major problem is backlog of cases in the courts.

TOTAL CASELOAD 1ST QUARTER FFY 1991	
TOTAL CASELOAD	240,195
AFDC/FOSTER CARE	151,799
NON-AFDC	70,074
AFDC/FOSTER CARE ARREARS	15,997
NON-IV-D	2,325

CHILD SUPPORT COLLECTIONS 1ST QUARTER FFY 1991	
TOTAL IV-D COLLECTIONS	8,100,810
AFDC/FOSTER CARE/ARREARS	3,102,376
NON-AFDC	4,998,434
IRS TAX OFFSET	82,201
INCOME WITHHOLDING	5,479,540

TOTAL PAID TO FAMILIES 1ST QUARTER FFY 1991	
TOTAL PAID TO FAMILIES	6,697,473
PAID TO AFDC FAMILIES	1,867,592
PAID TO NON-AFDC FAMILIES	4,829,881

TOTAL RECOVERY 1ST QUARTER FFY 1991	
TOTAL RECOVERY	1,942,487
STATE SHARE OF RECOVERY	389,857
FEDERAL SHARE OF RECOVERY	1,552,630

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[10] Association For Child Support Enforcement, 1990.

HUNGER IN MISSISSIPPI

CHILD HUNGER IN MISSISSIPPI[11]

	Mississippi	United States
Percent of families with children under 12 who are hungry	19.4	12.3
Percent of children under 12 who are hungry	18.9	12.8
Percent of families with children under 12 who are hungry or at-risk of hunger	42.8	27.6
Percent of children under 12 who are hungry or at-risk of hunger	38.7	26.8

SCHOOL MEALS PROGRAMS[12]

	Free	Reduced	Paid	Total
School Lunch	41,893,525 or 61%	5,393,151 or 8%	21,543,636 or 31%	68,830,312 or 100%
School Breakfast	18,659,438 or 85%	1,282,870 or 6%	2,114,220 or 9%	22,056,528 or 100%
Summer Breakfast	N/A	N/A	N/A	477,385
Summer Lunch	N/A	N/A	N/A	1,732,133
Summer Snacks	N/A	N/A	N/A	81,898
Summer Supper	N/A	N/A	N/A	30,097

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[11] Community Childhood Hunger Identification Project, Food Research and Action Committee, 1991.

[12] Mississippi State Department of Education, November 1990.

WIC AVERAGE MONTHLY PARTICPATION DATA FOR FY 1990[13]
2nd Congressional District

County	Women	Infants	Children	Total	% Potential
Tunica	108	172	433	713	67%
Panola	272	412	741	1,425	67%
Quitman	149	201	541	891	74%
Coahoma	451	558	1,274	2,283	67%
Tallahatchie	268	303	801	1,372	88%
Bolivar	522	720	1,589	2,831	70%
Sunflower	303	595	1,253	2,151	72%
Leflore	455	678	1,525	2,688	75%
Grenada	271	376	630	1,277	113%
Carroll	51	67	181	299	45%
Holmes	268	414	1,213	1,895	86%
Madison	272	463	909	1,644	52%
Hinds	1,412	2,570	3,606	7,588	60%
Yazoo	268	353	823	1,444	68%
Attala	239	274	641	1,154	88%
Claiborne	109	150	376	635	83%
Jefferson	136	147	545	828	105%
Washington	589	971	1,838	3,398	55%
Humphreys	185	210	662	1,057	74%
Warren	327	509	888	1,724	69%
Issaquena-Sharkey	140	182	429	761	78%
Mississippi	20,653	29,129	52,444	*	*

* In 1989 in Mississippi, 108,000 people were enrolled in the WIC program and 102,226 people participated in the program. The difference in enrollment and participation is approximately 4-5%.

JANUARY 1991 FOOD STAMP PARTICIPATION DATA FOR MISSISSIPPI[14]

Total number of households participating	183,688
Total number of people participating	510,179

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[13] Mississippi State Department of Health, October, 1990.

[14] Mississippi Department of Human Services, 1991.

ELDERLY MEALS PROGRAM[15]

Mississippi 1990 Totals

	Number of Clients Served	Number of Meals Served
Home Delivered	11,124	1,833,678
Congregate	8,724	1,185,911

Second Congressional District
Projected Data for Total Meals to be Served in 1991

County	Congregate	Home Delivered
Tunica	10,330	8,880
Panola	19,450	13,080
Quitman	2,598	3,760
Coahoma	15,090	21,560
Tallahatchie	7,943	13,220
Bolivar	38,250	29,232
Sunflower	25,325	27,051
Leflore	34,049	43,645
Grenada	7,839	10,913
Carroll	15,676	28,131
Holmes	31,356	43,644
Madison	11,204	28,000
Hinds	92,342	177,000
Yazoo	19,920	71,500
Attala	7,839	10,911
Claiborne	17,000	20,097
Jefferson	3,000	6,264
Washington	40,000	27,051
Humphreys	10,750	6,525
Warren	6,225	28,449
Issaquena-Sharkey	6,250	10,962
Mississippi	1,199,620	1,740,388

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[15] Mississippi Department of Human Services, Division on Aging and Adult Services, Council on Aging, 1991.

Selected Statistics on the Elderly Population in Mississippi

1990 population:

Category	Percent	# of Persons
60 +	100.0	430,000
Black	32.1	138,030
White	67.5	290,250
Live Below Poverty	30.0	129,000
Live in Rural Areas	53.4	229,620
Live alone	24.9	107,070

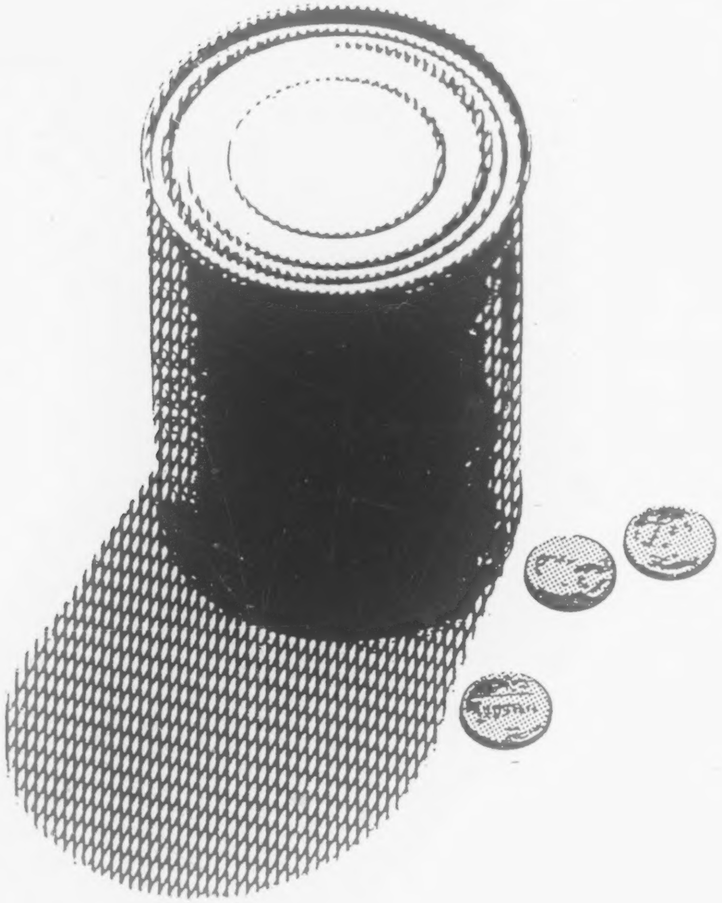
Income, Health and Nutrition

- 92 % of all elderly had incomes less than $ 16,000
- 57 % of all elderly had from fair to poor health, with 13.4 % reporting really serious health problems
- 27 % of elderly are on some kind of special diet
- 15 % are unable to prepare their own meals
- 8 % have trouble getting enough food
- The Congregate Meals Program serves less than 1 % of the elderly
- The Home Delivered Meals Program serves only 1% of the Elderly population.
- 96 % know about the Food Stamp Program, but only 36 % have used the program

Source: 1990 Program Performance Reports, 1985 Older Mississippians Needs Assessment.

Higher Prices, Fewer Choices:

Shopping for Food in Rural America



PUBLIC VOICE FOR FOOD AND HEALTH POLICY

EXECUTIVE SUMMARY

Introduction

More than nine million people live in poverty in rural America. However, the rural poor are among the most invisible of Americans, even though the poverty rate in rural communities is higher than in metropolitan areas. In 1987, the poverty rate in rural America was 16.9 percent, as compared to 12.5 percent in metropolitan areas. Since 1978, poverty has increased by more than 25 percent, bringing the total number in poverty in rural America to 9.1 million.

The rural poor are a group profoundly hampered by poor nutrition and the debilitating health consequences that follow. Since 1984, Public Voice has documented the serious nutritional shortcomings in the diets of the rural poor and identified some of the causes of poor nutrition.

The Food Stamp Program is the government's primary program to prevent the rural poor from going hungry. However, there is growing evidence that benefit allotments are not adequate to actually purchase a minimally adequate diet.

Food stamp benefit allotments are set each year based on the cost of the "Thrifty Food Plan" (TFP) as defined by the U.S. Department of Agriculture (USDA). USDA sets these costs by examining average food prices in supermarkets solely in urban areas. There is no consideration of the prices faced by the rural poor who may not even have a supermarket nearby and who instead rely on smaller "mom and pop" stores which consistently have higher prices and fewer choices.

Public Voice undertook this nationwide study to examine the access to supermarkets in rural America and to determine the actual cost and availability of foods in a TFP marketbasket and persistently poor rural America. During the summer of 1989, a team of two Public Voice surveyors traveled to 33 persistently poor rural counties throughout the United States. They priced a Thrifty Food marketbasket in 133 food stores, including 51 supermarkets and 82 small to medium food stores, consisting of 77 different foods.

The study found rural poor communities dependent upon smaller, more expensive stores for their food because few competitively priced supermarkets were located in these areas. It found unstocked shelves, and a dearth of fresh fruits, vegetables, and meats. Most important, the survey found the price of a "Thrifty Food Plan" marketbasket far exceeded food stamp allotments no matter where the rural poor shopped.

Key Findings

1. Food stamp benefit allotments are not adequate to purchase the foods necessary for the minimally adequate diet, the Thrifty Food Plan, for persons living in persistently poor rural America.

The Thrifty Food Plan is the government's formula to define the costs and foods needed to obtain a minimally adequate diet. The cost of the TFP is used to set benefit allotments for the Food Stamp Program and is the baseline used in determining poverty levels.

In 1989, the U.S. Department of Agriculture valued the weekly cost of the Thrifty Food Plan for a household of four at $75. However, the cost of a TFP marketbasket is substantially higher in persistently poor rural America than USDA's defined cost.

In 1989, the average cost for a week's worth of TFP groceries for a household of four in persistently poor rural America was $102 in small/medium stores; a cost 36 percent higher than USDA's 1989 maximum food stamp benefit allotment for that size household. This amounts to a $27 a week shortfall in food stamps needed to actually purchase the TFP groceries in small/medium stores.

In the more competitively priced supermarkets, the average cost for a week's worth of TFP groceries for a household of four was eight percent higher than USDA's cost. In addition, in only one out of five supermarkets (19.6%) could a TFP marketbasket be purchased for the maximum food stamp benefit allotment of $75 or less.

These findings probably underestimate the actual cost because foods selected for the study's marketbasket were among the least expensive foods in USDA's 31 categories. In addition, surveyors always selected the cheapest item regardless of package size or brand name when pricing food items at the stores. Therefore, consumer preference for specific foods or brand name items was ignored.

2. One out of every three food stamp dollars is spent in the smaller food stores in persistently poor rural America, while the other two dollars are spent in supermarkets.

In 1988, the average percent of coupons redeemed in the smaller food stores in persistently poor rural America was 32 percent. The remaining 62 percent of coupons was redeemed in supermarkets.

A larger share of the coupons is redeemed in the smaller stores in persistently poor rural America than in the nation as a whole. In 1988, 32 percent of the food stamps was redeemed in the smaller stores in persistently poor rural America as compared to 20 percent redeemed in the nation as a whole.

3. Rural America has limited access to the competitively priced supermarkets.

There are disproportionately fewer supermarkets in rural America than in urban America. In 1988, of the 29,738 supermarkets in operation less than one-third (30%) were located in rural America, even though the vast majority (77%) of counties are rural. As a result, there are nearly eight times as many supermarkets per county in urban America as in rural America. The average number of supermarkets per county in rural America was 3.8, while in urban America it was 29.2.

Not only are there fewer supermarkets per county, but the average number of square miles per supermarket is nearly 10 times larger in rural America than in urban America. In 1988, rural America had an average of one supermarket every 265 square miles, while urban America had one supermarket every 27 square miles.

Persistently poor rural America has even fewer supermarkets than the non-poor areas in rural America. There are roughly one-third more supermarkets per county in rural non-poor America than in persistently poor rural America. In 1988, the average number of supermarkets in persistently poor rural America was 2.9, compared to 3.9 in rural non-poor America.

4. The availability of fresh fruits, vegetables and meats is extremely limited in the small/medium stores in persistently poor rural America.

During the summer of 1989, 23 percent of the small/medium stores did not stock any fresh vegetables. An additional 35 percent of these stores only carried between one and four fresh vegetables and those most frequently stocked were onions and potatoes.

The availability of fresh fruits is even more limited in small/medium stores. One out of three (33%) stores stocked no fresh fruits. An additional 43 percent only carried between one and four fresh fruits and those most frequently stocked were bananas, apples, oranges and grapefruit.

As with fresh produce, small/medium stores in persistently poor rural America offered a limited selection of fresh meats. Almost one-third (30%) of these stores stocked no fresh meats. An additional one-third only carried between one and four fresh meats.

Key Recommendations

1. Provide Adequate Food Stamp Benefit Allotments to Recipients

▸ **Raise food stamp benefit allotments 5 percent above the cost of the Thrifty Food Plan in FY 1991 and an additional 3 percent for the next four years. By FY 1995 benefit allotments will be increased 17 percent above the cost of the TFP.**

This study shows that a 17 percent increase in food stamp benefit allotments is necessary if the rural poor are to have the purchasing power to obtain the minimally adequate diet, the Thrifty Food Plan. This figure takes into account the proportion of purchases made in small/medium stores as well as in supermarkets.

In addition, our findings concur with urban studies showing similar cost discrepancies. Findings from one study showed that the cost of the Thrifty Food Plan in 1987 in Los Angeles' supermarkets was 15 percent higher, in medium stores 26 percent higher and in small food stores 38 percent higher than USDA's established cost.

In another study, conducted in three areas in New York State in 1989 showed that compared to the maximum food stamp benefit allotment, the cost of the TFP marketbasket in supermarkets was 4.6 percent higher in a suburban county, 8.9 percent higher in a rural county and 14.1 percent higher in the borough of Brooklyn. Marketbasket costs in small/medium stores were all consistently higher, ranging from 17.5 to 21.9 percent higher than maximum food stamp allotments.

▸ **Revise food stamp benefit allotments twice a year rather than once a year.**

Each month the cost of purchasing the Thrifty Food Plan is updated using the Consumer Price Index based on data collected by the Bureau of Labor Statistics. Since 1980, food stamp benefit allotments have been revised only once a year. Therefore, in any given year, food stamp benefits lag 3 to 15 months behind the actual cost of the plan.

▸ **Index the minimum benefit of $10 provided to one and two person households to reflect inflation.**

The current minimum benefit has not been increased since 1977, while the cost of the Thrifty Food Plan has risen 89 percent over this same period.

▸ **Re-evaluate the methodology used to determine food stamp benefits.**

This study shows that the methodology used to determine the cost of the Thrifty Food Plan and thus food stamp benefit allotments for the rural poor is inappropriate. USDA's cost determination of the TFP is not based on food prices incurred by the rural poor. Rather it is based primarily on food prices in large supermarkets in major urban areas. Moreover, the indexes are based on the average consumer, rather than the low-income consumer.

These indexes therefore are not realistic measures of what the rural poor actually pay for food. As this study showed, the rural poor have limited access to supermarkets and must shop for at least some of their groceries in the smaller more expensive stores. In addition, even if the rural poor shop in supermarkets, their costs are still higher than the food stamp benefit allotments.

▸ **Move toward replacing the Thrifty Food Plan with the Low Cost Food Plan as the standard for setting food stamp benefit levels.**

The Thrifty Food Plan is only intended to provide for a minimally adequate diet on an emergency basis, not sustain good nutritional status over a long period of time. Both the Society for Nutrition Education and the American Public Health Association passed policy statements in 1980 criticizing the inadequacy of the Thrifty Food Plan.

2. Assist Smaller Food Stores Become More Competitively Priced and Offer a Wider Variety of Fresh Produce and Meats.

▸ Establish a three to five year federal grant demonstration program to support the creation of cooperative wholesale buying with established wholesalers for small/medium food markets in economically depressed rural areas.

A major obstacle to selling foods at comparable prices to area supermarkets is the inability of small/medium stores to purchase foods from wholesalers at the same prices as supermarkets. Approximately three out of four (72%) owners of small/medium food stores reported they were paying more to purchase foods from wholesalers than from area supermarkets. When asked why, the most often heard response was that they don't buy the volume of food that supermarkets do and thus pay more.

The Hartford Food System in Connecticut recognized this problem and several years ago organized local small/medium food stores into the Hartford Grocers' Association. As members of this association, the smaller stores have access to substantially lower wholesale prices through collective buying agreements. The association also provides collective advertising, mutual aid and support to its member stores. Starting in the summer of 1990, association members will buy many of their fresh food directly from local farmers. This urban solution could be replicated in a rural setting.

▸ Establish low interest loans for the improvement of small/medium food markets in economically depressed rural America.

Many of the smaller stores need to modernize their stores and update their equipment. But for many, they either can't procure or can't afford to take out a conventional loan. With little additional cost, the federal government could earmark a certain percentage of the Small Business Administration or the Farmers Home Administration loan programs for this program. This would enable store owners to gain access to low interest loans.

▸ Establish low interest loans for the purchase of the smaller food stores in economically depressed rural areas.

Rural America depends heavily on smaller food stores. However many are closing when either the store owner retires or dies. It is extremely difficult to sell a smaller food store. While the store may have made a marginal profit, the debt burden of taking out a conventional loan to purchase the business and the overhead is too high for many potential buyers to make a profit. As a result, food stores are simply closing. This not only means that people have to travel farther to do their shopping, but that local community employment and dollars are leaving that town.

Partners For Improved Nutrition And Health

P.O. Box 531, Greenwood, MS 38930

Partnership

Partners for Improved Nutrition and Health is an experimental program sponsored by the Freedom from Hunger Foundation, the Mississippi Cooperative Extension Service, and the Mississippi State Department of Health. The program is operating in the Delta area of Mississippi.

Goals

The primary goals of the overall program:

- To encourage local self-help activities that yield sustained improvements in the nutrition and health of low-income residents.

- To establish models for self-help nutrition and health improvement which are suitable for replication in other parts of the rural South.

Design

The program consists of two projects:

- Partners for Life is being conducted in Leflore County with the Mississippi Cooperative Extension Service as the lead agency.The assumption being tested is that an integrated inter-agency intervention can decrease the prevalence of low birth weight among the low-income population. The project emphasizes self-help.

- Community Health Advisor Network is being implemented in Humphreys County under the leadership of the Mississippi State Department of Health. The assumption is that community residents, with the support of local and state agencies, can effectively identify health and nutrition related problems in their neighborhoods, and can plan and carry out innovative projects to deal with those problems. It emphasizes community self-help.

HUMPHREYS COUNTY
HEALTH ADVISORS NETWORK

Community Profile

A. Rural town/rural	**13,295 population**
B. Unemployment Rate	**9.9% (1989)**
C. Per Capita Income	**$6,113 (1983)**
D. Education (percent population over age 25, 1980)	
Less than 12 years	**77%**
12 years	**11%**
13-16 years	**7%**
16+ years	**5%**

Health and Social Status of Target Population

- The infant mortality rate (1983-1987) is 30.8 (per 1,000 live births), higher than French Guiana, Chile, and Malaysia.
- Low birth weight occurred in 8.7% of all births (1988), and 25% of births were to teenage mothers.
- Forty-five percent of the county's population lives on incomes below the federally established poverty level, and one out of three families is dependent on the Food Stamp Program.
- Eighty-five percent of all children attending public school are performing below the 50th percentile nationally (1988). Of the approximately 300 students who enroll in the first grade each year, only 156 will graduate from high school.

Problem

Excessive infant mortality and high accidental death rate are symptomatic of an intractable complex of poverty-related public health and nutrition problems. Rising service-delivery costs, insufficient outreach, lack of program coordination, and dependency on welfare programs hamper corrective measures.

Process

Identify Natural Helpers

Identify people and networks that local residents rely on for advice and assistance in solving health and other problems.

Develop and Conduct Training Program

Develop a 10-week skills-based training program combining health and nutrition promotion with community development methods. Offer the program to natural helpers, allowing them to become certified Community Health Advisors.

Establish Agency Linkage

Community Health Advisors and agency personnel identify major causes of preventable death and community-perceived health issues, and devise solutions that use the Health Advisor's neighborhood advising, assisting, and action-organizing roles.

Results

- Fifty-two volunteer Community Health Advisors completed the 10-week training program.
- Health Advisors organized two community clean-up campaigns, three health-screening fairs, an emergency food pantry, self-help programs for the elderly, and youth and adult recreation programs.
- Health Advisors make approximately 170 helping contacts per week, assisting their neighbors with a wide range of health and social issues.
- Joint planning between the Community Health Advisors and the Department of Health results in combined action on public health priorities.

LEFLORE COUNTY
PARTNERS FOR LIFE

Community Profile

A. Urban/Rural	**41,294 population**
B. Unemployment Rate	**10.9% (1989)**
C. Per Capita Income	**$7,487 (1983)**
D. Education (percent population over age 25, 1980)	
Less than 12 years	**70%**
12 years	**11%**
13-16 years	**10%**
16+ years	**9%**

Health Status of Low-Income Women and Infants

- Low birth weight occurred in 10.5% of all births in 1988 in Leflore County, and in 12.5% of births to African-American mothers.
- Infant mortality rate (1984-1988) in the county is 17.7 and 20.2 in the African-American community.
- Hematocrit levels below the 5th percentile (indicating high risk for anemia) were found among 16.1% of maternity patients in 1985.
- Current WIC statistics show that less than 5% of all WIC clients in the county are breast-feeding their infants.

Problem

Mississippi's highly successful WIC program is constrained by limited resources for nutrition education. Low birth weights, elevated infant mortality, unfavorable weight gain during pregnancy, and late and irregular prenatal care persist, especially among African-American and low-income populations.

Process

Identify and Train EFNEP Educators

Recruit and train women from low-income neighborhoods to serve as EFNEP Educators. They become skilled in practical aspects of food and nutrition, health, and parenting as well as methods of informal and participatory training.

Develop Experimental Education Plan

Develop a curriculum for maternal and infant care, nutrition, and health education and parenting. Project staff, EFNEP Educators, and community leaders work together on the design.

Establish Inter-Agency Referral

Establish an inter-agency referral and information management system between the WIC program and EFNEP. This allows for close monitoring of client health and nutrition status.

Conduct Partners for Life Sessions

EFNEP Educators teach 20 lessons, in homes and small groups, to low-income pregnant women who are considered to be at-risk and high-risk, with a majority being teen and unintended pregnancies.

Results

- Eighty-five clients enrolled in first year of experimental program
- Demonstrated systems of inter-agency collaboration
- Expanded program to four additional Delta counties.
- Increased rates of breast-feeding among the target audience

Mississippi State Department of Health

Mississippi Nutrition Surveillance System 1988 Report

Bureau of Health Services, Terry Beck, Chief
Nutrition Services, Agnes Hinton, Director
SSPUN Project Coordinator, Ann Beardshall
PNSS Coordinator, Joan James

Abstract

The purpose of nutrition surveillance is to continuously monitor and evaluate the nutritional status of an at-risk population. In Mississippi, the two systems in place in 1988 were Statewide Pediatric Nutrition Surveillance and during the fourth quarter of the year, the Surveillance of Severe Pediatric Undernutrition (SSPUN) in Health District III.

Pediatric Nutrition Surveillance (PedNS) includes indicators of poor nutritional status such as the prevalence of growth stunting or shortness, underweight, overweight, and anemia. In Mississippi, children covered by PedNS are applicants for the Special Supplemental Feeding Program for Women, Infants, and Children (WIC), ages birth to five years; almost all participate in WIC.

Through the Pediatric Nutrition System, the following data were obtained for 1988:

Shortness exists in 7.6% of the children, down from 10% in 1987. When infants with low birthweight up to age six months are excluded from the data, the incidence of shortness drops to 6.6%. This is considerably lower than the national rate of shortness for PedNS in 1988 of 10.1%.

The prevalence of thinness is 7.8%, down from 9.3% in 1987 and 10.2% in 1986. This is slightly lower than the national PedNS rate of 8.4% for thinness.

The PedNS rate of overweight statewide in 1988 is 7.8%, down from 9.3% in 1987 and 10.2% in 1986. This is slightly lower than the national PedNS rate of 8.4% overweight in 1988.

The risk of iron deficiency anemia declined dramatically in 1988 to 6.5%, down from 8.9% in 1987. When Mississippi entered PedNS in 1984, the prevalence rate for anemia was 11.2%. The rate has also declined significantly at the national level, with a 6.7% incidence of anemia for 1988 PedNS data.

The low birth weight rate of 10.6% for Mississippi PedNS data is comparable to the U.S. PedNS rate of 10.4%, and is similar to the rate of 10.8% in Mississippi in 1987. The Mississippi rate of low birthweight by ethnicity is lower than the national data with blacks at 11.5%, Hispanics at 9.2%, and whites at 8.4%, and blacks at 13.4%, Hispanics at 10.2%, and whites at 8.6% in the National PedNS data.

The incidence of breastfeeding in Mississippi, while improved from 12.1% in 1987 to 13% in 1988, is much lower than than the US PedNS incidence of 38.5%. However, the majority of Mississippi women who did breastfeed continued for six months compared to about one month for the US PedNS data.

Surveillance of Severe Pediatric Undernutrition (SSPUN) includes prevalence of underweight (height/weight less than the 3%), anemia (hematocrit of 25 or less or hemoglobin of 8 or less), and any diagnosed state of malnutrition. It covers all children from six months of age to six years of age.

From July to December, 1988, 36 children in Health District III were identified as severely undernourished through the SSPUN system.

Planning was initiated in 1988 for the Pregnancy Nutrition Surveillance System (PNSS), which monitors maternal weight, anemia, smoking behaviors, and alcohol consumption.

While dramatic improvements were made in several areas in 1988, as compared to 1987, the results continue to confirm that the infants and children served by the Mississippi WIC Program are at higher nutritional risk than the general pediatric population. The prevalence rates exceed the expected norms for children of similar ages for shortness, overweight, and low hematocrit (an indicator of risk for anemia). Low birthweight is more prevalent in children in the WIC program than in the state as a whole. Breastfeeding is less prevalent among the WIC population than the general population.

Recommendations

When addressing each nutrition indicator (shortness, thinness, overweight and anemia) Mississippi's trends seem to be improving. To insure our progress toward continued improvement, the following recommendations are made:

- Broaden nutrition surveillance to include children from other programs such as EPSDT and women participating in the Family Planning Program.
- Refine follow-up systems for high risk children identified through the Pediatric Nutrition Surveillance System, and include overweight children.
- Expand SSPUN to statewide coverage.
- Continue maintenance of quality assurance protocols to assure accuracy of anthropometric and hematological measurements.
- Continue use of Nutrition Surveillance Data in program planning at the county, district and state levels.
- Increase promotion and support of breastfeeding
- Develop and implement procedures that reduce or prevent overweight.

The Mississippi Surveillance of Severe Pediatric Undernutrition Project

1988 - 1990

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I. Executive Summary

In response to a lack of objective statistics indicating the extent of pediatric undernutrition, the U. S. Congress provided funds for the Centers for Disease Control (CDC) to investigate the feasibility of developing a surveillance system for severe pediatric under nutrition. In 1987, in response to this charge, the CDC announced a request for proposals to establish a pilot surveillance of severe pediatric undernutrition system in both rural and urban areas. The Mississippi State Department of Health, along with three other state health departments, was awarded a three year grant beginning in October, 1987 to establish such a system. The Mississippi State Department of Health viewed this as an opportunity to acquire the funding and technical assistance necessary to establish such a system as well as an opportunity to explore with other states and CDC the most cost-effective methods to implement such a system.

The four project states worked with CDC in 1988 to develop common criteria for SPUN confirmation and a common questionnaire to determine SPUN risk factors. Methods of surveillance, however, varied among the states. The four populations chosen for surveillance in Mississippi were:

1. Death certificates of children >28 days to 6 years of age. The siblings of these deceased children represented the potential population for case finding. This group was chosen as a preliminary CDC pilot project at Grady Hospital, Atlanta, identified death of a sibling from any cause as a predictor of SPUN.

2. Referrals from various community agencies and providers and pediatric inpatients at the University of Mississippi Medical Center (UMC). UMC is the states' only tertiary level hospital.

3. Cases identified through WIC clinics, either directly at certification or from the monthly pediatric nutrition surveillance report received from the CDC.

4. Birth certificates of infants at high risk for mortality as indicated by a risk score calculated by the Mississippi State Department of Health Vital Statistics branch.

The areas chosen for surveillance were Health District III, the rural component, including nine Delta counties with some of the state's worst poverty and health status indicators, and Health District V, the urban component, including 10 counties, and the pediatric inpatients at the University of Mississippi Medical Center in Jackson. The two catchment areas and UMC's pediatric patients provided an opportunity to test the surveillance system in populations of varying risk factors and access to health care.

The common case definition criteria were:

. Weight for length or height below the 3%
. Hemoglobin below 8.0 gm/dl or hematocrit below 25% without
  hemoglobinopathy
. Absolute weight loss
. Clinically defined signs of malnutrition such as kwashiorkor
  without explanatory organic causes

There are an estimated 83,005 children in the 6 months to 6 year age range in the two districts. Using the populations and surveillance methods described in this report, 192 children, a prevalence rate of 2.31/1,000 population, met the criteria to be classified as a SPUN case. Of these 192 children, 104 (a prevalence rate of 3.56) were identified from District 3, while 88 (a prevalence rate of 1.64) were identified from the urban component, District V. There were 103 males and 89 females. Nonwhite children made up the larger portion of cases. The age range with the largest number of cases identified was those children ages 1-2 years. Most children's families were living at less than 100% of the poverty level. A large number of the children were living with mothers having less than a high school education. The age of mothers at the time of confirmation showed that the largest number of children had mothers in the 20-30 years age range, but 7 of the children were from households with mothers 41-50 years of age. There were more unmarried mothers than married.

Two of the populations under study, siblings of children in the project area who had died, and high risk infants identified through the birth certificate risk score, produced no confirmed cases of SPUN. The first may be due in part to the difficulty in locating these families and getting complete data on all their children. The second is primarily due to the excellent participation in WIC among the high risk infants. Of 1,300 babies identified based on birth certificate data as high risk, only 14 were not on WIC by age six months.

72 (37.5%) of the 192 SPUN cases were identified at the UMC, while 120 (62.5%) of the cases were identified through WIC certification data or the CDC Pediatric Nutrition Surveillance System.

Based upon the findings from the project, a follow-up system based on WIC CDC Pediatric Nutrition Surveillance is now implemented statewide, with the system currently undergoing refinement with the intent of including monitoring of follow-up given and provision of intensive nutrition counseling as needed as one component of the state's Nutrition Network for Children with Special Health Care Needs.

Potential alternate surveillance which could be implemented in the future would include incorporation of screening for underweight and anemia into the state's requirements for admission to day care centers, including Head Start, or kindergarten.

MISSISSIPPI'S

Perinatal High Risk Management/Infant Service System (PHRM/ISS)

Mississippi has one of the highest infant mortality rates in the nation. Infants weighing less than 1500 grams are:

- 40 times more likely to die during their first 4 weeks of life
- 5 times more likely to die during the first year
- 3 times more likely to have neurodevelopmental problems such as seizures, cerebral palsy and developmental delay

For every baby that dies, three will be born with lifetime handicapping conditions.

Preterm, low birthweight infants are the single largest contributor to Mississippi's high infant mortality rate as well as infant morbidity rate.

The objective of PHRM/ISS is:

- **to lower the infant mortality and morbidity rate in Mississippi through decreasing the incidence of low birthweight infants.**

A large number of poor pregnancy outcomes are preventable. The PHRM/ISS approach is to reduce the risk of poor outcomes by providing comprehensive, individualized, enhanced services through an interdisciplinary team approach to high risk pregnant women and infants.

Comprehensive and enhanced services include the following:

- Nutrition assessment/counseling
- Psychosocial assessment/counseling
- Nursing assessment/counseling
- Case management/care coordination
- Home visits
- Health education

STATE PROFILES

Statistics Related to JOBS Implementation in the South

Prepared for

JOBS and Education in the South:

New Linkages, New Issues

March 25-26, 1991
Decatur Holiday Inn
Atlanta, Georgia

Sponsored by
The Center on Budget and Policy Priorities
The Center for Law and Social Policy

STATE PROFILE FOR MISSISSIPPI

JOBS Program name:	**JOBS**
Starting date:	July, 1990
Statewide:	No; 9 counties[1]

Background Characteristics

Unemployment rate, 1990[2]	7.5%
Poverty rate, 1986-88 (national rank)[3]	25.8% (51)
% of Heads of Household With Less Than HS Diploma, 1986-88 (national rank for HS graduates)[4]	37% (48)
% With 0-8 Years of Schooling	21%
% With 9-11 Years of Schooling	16%
Total Adult AFDC Recipients, November, 1990[5]	58,700
AFDC-UP Program Prior to October 1, 1990	No
AFDC Maximum Benefit for Family of Three, January, 1991[6]	$120

Adult Education Data, 1988-89[7]

Total Enrollment	16,520
Total Spending	$1,644,791
Federal expenditures	$1,487,288
State and/or local expenditures	$ 157,503
State and/or local share of total spending (national rank)	9.58% (51)
Expenditure per student	$100

JOBS Program Data[8]

FY 90	Federal JOBS Funds Available	N/A
	Total Federal Funds (FFP) Claimed	N/A
FY 90	Federal JOBS/AFDC Child Care Claimed	N/A
FY 91	Federal JOBS Funds Available[5]	$12,732,546

JOBS Participation, December 1990[10]

Total Participants in JOBS Components (excluding assessment)	136
% in each component	
Education	52%
Job Skills Training	1%
Job Readiness Activities	2%
Postsecondary Activities	8%
Self-initiated Activities	18%
Job Search	15%
On-the-job Training	0%
Work Supplementation	0%
CWEP	0%
Other approved activities	3%

JOBS Expenditures, December 1990[11]

Total Spending	$71,265
% on assessment	93%
Spending on components, excluding assessment	$ 4,907
% by component	
Education	62%
Job Skills Training	26%
Job Readiness Activities	0%
Postsecondary Activities	0%
Self-initiated Activities	0%
Job Search	13%
On-the-job Training	0%
Work Supplementation	0%
CWEP	0%
Other approved activities	0%

Child Care Participation and Expenditures, December 1990[12]

Total Number of Families Receiving JOBS/AFDC Child Care	5
As % of families assisted by JOBS	1%
Total Child Care Spending (including transitional)	$22,573
Average monthly cost per child	$ 138

Notes

1. Summary of JOBS Program prepared by FSA/OFA/JOBS Task Force, U.S. Dept of Health and Human Services, 1/31/91.

2. "State and Regional Unemployment in 1990", USDL 91-74, Bureau of Labor Statistics, U.S. Department of Labor.

3. Analysis of Census data from the Current Population Survey, prepared by Jon Haveman and Sheldon Danziger for the Corporation for Enterprise Development, Washington, DC. National rankings include the District of Columbia.

4. Ibid. National rankings are based on the proportion of heads of household in the state who are high school graduates, in descending order.

5. Family Support Administration, U.S. Dept. of Health and Human Services, 2/11/91.

6. Congressional Research Service, January 1991.

7. Office of Vocational and Adult Education, U.S. Dept. of Education, January 1991. One measure of level of effort in adult education is the extent to which a state commits funding to the program beyond the minimal (10% in 1988-89) state/local match required under the Adult Education Act. National rank indicates how states compare under this measure of level of effort.

8. Summary prepared by OFA/FSA from FSA-331 forms, as submitted by the States, U.S. Department of Health and Human Services, 1/9/91. The total FFP claimed for FY 90 may rise as unliquidated obligations are spent; states have two years in which to file claims.

9. JOBS-FSA-IM-91-1, Family Support Administration February 1, 1991.

10. Calculations derived from the numbers reported on FSA-104 forms, First Quarter 1991, as submitted by States. For North Carolina, the December 104 form actually reflects November participation.

11. Ibid.

12. Ibid. For Florida, child care participation data is not included because the data currently in the system lags far behind actual participation.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
COUNCIL ON AGING

Written Comments Submitted

for

Billie J. Marshall, Director

on

" Barriers to Adequate Diet and Nutrition for Older Mississippians"

May 3, 1991
Bolton, Mississippi

Barriers to Adequate Diet and Nutrition for Older Individuals in Mississippi

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Nutrition programs under Title III of the Older Americans Act of 1965 were designed to address a number of problems faced by older persons in this nation as well as Mississippi. Such problems include dietary inadequacy, declining health status, social isolation and limited access to support and health services.

Among certain sub-populations of the elderly in the state of Mississippi, such as the poor, ethnic minorities, the isolated and handicapped, etc., these problems are found in many cases to be more acute. The nutrition program was designed to emphasize services to these groups. Special outreach efforts are designed to encourage their participation and meal sites are located in the communities where they live.

The major activity of the nutrition program is to provide one nutritionally balanced meal per day, five days a week to the elderly either in congregate dining sites or in the homes of homebound clients. This meal is the mid-day or luncheon meal. Although the elderly are not required to purchase these meals, they are encouraged to contribute to the cost of the meal. Contributions are used to purchase additional meals and for program expansion. In addition to providing a nutritionally balanced meal, the nutrition program also seeks to ameliorate isolation and loneliness that can characterize less mobile elderly citizens.

While the dietary and social aspects of the nutrition program are the most essential elements, nutrition sites are encouraged to provide other certain supportive services to participants. These services include recreation, transportation, escort services, nutrition education, shopping assistance, counseling and information and referral.

Mississippi has been actively involved in providing nutrition and supportive services to the elderly populace of the state since the inception of the Older Americans Act. The nutrition program is one the most demanded and important services provided to the elderly. It should be noted that we have been committed to the program from the beginning and that Mississippi was the first state in the nation to implement a nutrition program for the aged under the Older Americans Act.

The aging population continues to grow faster in this state than one may expect. This growth has been so dramatic that financial and human resources have not been able to keep pace with the increasing need for services. According to 1989 census reports, there are 430,000 individuals sixty years of age and older that are eligible for services under the Older Americans Act in Mississippi. Compared to this number, 6,440 older Mississippians participated in the state wide congregate meals program and 8,209 participated in the home delivered meals program during the calendar year ending December, 1990. (The number served is directly related to the amount of funds available for the program).

Given the eligible population, the number of the participants in the program is low. This situation is compounded by the existence of long waiting lists for supportive services and nutrition services. Approximately 230 older persons are on the waiting list for congregate meals and 1,067 for the home delivered meal. Overall there were approximately 5,020 persons eligible for supportive services on waiting lists through the end of December 1990. Unfortunately these individuals may remain on a waiting list for a long period of time due to the lack of available federal, state and local resources to meet their needs.

Inadequate funding, fiscal austerity and budget constraints are realities for all of us working with or on behalf of the elderly in this state. Expanding and/or maintaining existing nutrition programs and other supportive services presents many challenges.

The State Unit on Aging recognizes that nutrition is among the many critical factors affecting the health and longevity of older Mississippians. Nutrition has extensive effects on both their morbidity and mortality. Our observation is that improving the nutritional status of the elderly is the most practical of all approaches for extending life expectancy and compressing the period between morbidity and mortality.

Although the economic status of many older persons has been improving the past ten years, many elderly Mississippians still fall into the low-income group. These persons have always had a low level of income, and old age merely compounds the problems of a lifetime of poverty or near poverty. Elderly Blacks as a whole in this state are more economically disadvantaged. Though there are fewer poor blacks than poor whites among the aged in this state, the proportion of elderly blacks who are poor certainly outweighs that of the white populace.

The effects of a declining U. S. economy, especially that of Mississippi, with its spiraling rate of inflation systematically diminishes the purchasing power of persons living on relatively fixed incomes. Because of this, the amount of income spent on food is often very limited. It is unfortunate, but most food purchases made by the elderly are for items which contain starches and fats. High protein and minerals are not the food groups of choice. The elderly, especially the Black Elderly often purchase these foods because they are cheaper and provide a quick source of energy for physiological functioning. In addition to these longtime dietary habits, there is not enough education relating to nutritional needs for healthy living.

Realizing that there is a correlation between age and low-income, the economic status must become an important concern of those who are deeply committed to food and nutrition issues and policies for the elderly.

While the economic well-being of the elderly has been improving, findings in a recent report by the USDA indicates.....

" That there is a substantial substrata of low-income elderly, especially the older-old and those living alone, that are economically vulnerable and at nutrition risk."

Mississippi's elderly profiles are consistent with these findings. Because Mississippi is basically a rural state and in small towns the population of older individuals is sparsely located and isolated, the problem is compounded and these individuals are placed in double jeopardy.

Nutritional risk factors include, but are not limited to diabetes, obesity, hypertension, congestive heart disease, stroke, and cancer. Again, these physiological problems are associated with several factors including income, education, and nutrition.

In addition to the elderly low-income characteristics, most of Mississippi's elderly live on fixed income while retail food prices increase rapidly. This situation has generated the need for public assistance to help ease the income burden. This population is often able to increase their food purchasing power by participating in the food stamp and commodities food distribution programs. However our review of the participation rates indicate that many of Mississippi's elderly that are eligible for food stamp benefits and surplus food items are not participating in these public food assistance programs. This is mainly because of a lack of access to transportation and the cost of transportation, when it is available, to get to the appropriate local agency for program certification - which is a federal requirement. In addition, the elderly individual, in many instances because of physical constraints, is unable to stand in line for a long period of time to access these services.

Public transportation usage is relatively infrequent among the majority of older persons. Additionally, public transportation is basically unavailable in Mississippi. In rural Mississippi, especially, there is often no transportation of any kind with the exception of limited transportation provided through programs funded by the State Department of Economic Development and Community Services, Energy and Transportation Division.

Further, there is also evidence that rural and public transportation systems have declined in recent years. The elderly are particularly affected by this situation. The isolated rural elderly in Mississippi are often unable to utilize essential and valuable food and nutrition services, as well as medical, recreational, educational and social services because of their forced social isolation and restricted mobility.

Although we find that federal food programs target older persons who are most in need, limited federal resources do not meet the needs of all older persons who presently need nutritional assistance. There are also implications that in the years to come there will continue to be a substantial number of older low-income persons who will be at nutritional risk. We would therefore suggest that the federal system examine its funding mechanisms and identify financial resources that will assist state and local governmental agencies in meeting the nutritional needs of elderly individuals.

In summary, it is the opinion of the State Unit on Aging that there is a broad base of nutritional and other services available to meet the needs of the older population. However, the problem is the lack of available financial and human resources to meet the vast number of individuals needing services.

The Mississippi Department of Human Services, Division of Aging and Adult Services, Council on Aging, offers the following recommendations to overcome some of the major barriers to effectively serving the elderly.

- That the federal regulations governing certification and participation in the food stamp program be reviewed. Attention should be given to mail-in certification procedures which would allow the isolated and immobile elderly to take advantage of a truly needed service to supplement their food budget.

- That programs should be developed and implemented at the federal/state/local level that are truly health promotional, and preventive, for elderly persons in both urban and rural areas, with a greater emphasis on the rural, isolated elderly.

- That appropriately funded programs be identified and implemented that will link older people with governmental and voluntary programs that provide money for food, commodity foods, congregate and home delivered meals.

- That funding be increased for nutritional screening, counseling and education that will have a lasting impact on the health longevity of the elderly.

- That the U.S Department of Transportation target more resources and programs for rural transportation services in the geographically rural areas of the state.

- That federal/state and local governments engage in-depth futuristic planning for the diverse population of 60 plus. Coordination and collaboration must become a major priority in planning, policy development and implementation of programs for the elderly. Agencies on the federal and state level such as USDA, ACTION, HUD, Health and Human Services, Mental Health, and other health, human and social service organizations implement a mechanism to review and identify ways for better coordination of services and programs to meet the needs of the elderly, in addition to making available funds to effectively implement more beneficial supportive service programs.

Selected Statistics on the Elderly Population in Mississippi

1990 population:

Category	Percent	# of Persons
60 +	100.0	430,000
Black	32.1	138,030
White	67.5	290,250
Live Below Poverty	30.0	129,000
Live in Rural Areas	53.4	229,620
Live alone	24.9	107,070

Income, Health and Nutrition

- 92 % of all elderly had incomes less than $ 16,000
- 57 % of all elderly had from fair to poor health, with 13.4 % reporting really serious health problems
- 27 % of elderly are on some kind of special diet
- 15 % are unable to prepare their own meals
- 8 % have trouble getting enough food
- The Congregate Meals Program serves less than 1 % of the elderly
- The Home Delivered Meals Program serves only 1% of the Elderly population.
- 96 % know about the Food Stamp Program, but only 36 % have used the program

Source: 1990 Program Performance Reports, 1985 Older Mississippians Needs Assessment.

Testimony of Mrs. Beatrice J. Branch, Executive Director, Mississippi Department of Human Services

To Chairman Hall, Congressman Espy and other distinguished members of our nation's most esteemed governing body, on behalf of Governor Ray Mabus, I welcome you. I want to express my pleasure at having been invited to provide testimony on the issues of hunger and poverty in Mississippi. Let me begin by attesting to the fact that Mississippians are still hungry and Mississippians are still poor; but, Mississippians continue to work without fatigue to alleviate these ills. And sirs, I am happy to report today that while much is left to be accomplished, progress is being made.

I realize that time allotted for my testimony is very limited. However, I want to reference a significant change in the State's organizational structure since your 1987 visit, which has positively influenced our welfare reform efforts. I will then follow up with a synopsis of how the welfare reform/JOBS program works in our State, touching on some of the problems to be resolved and strategies being tested to provide options to public assistance.

As a result of the passage of the Executive Branch Reorganization Act of 1989, the Mississippi Department of Human Services was created. It is one of the largest agencies in state government, with 5000 employees and an annual budget in excess of $380,000,000. Each year, the Department delivers some 60 separate human service programs to 25% of Mississippi's population. Our mission is to deliver, within established guidelines, a broad range of services to a diverse population in a professional, timely, accurate and compassionate manner. We work to further that mission by assisting those in need to overcome adversity, dependency and lack of self-esteem, and gain self-confidence and self-sufficiency. Over the last eighteen months, we have worked zealously to assure that this mission is accomplished, and next month we will be unveiling our five-year plan to assure that our efforts and energies remain focused.

It is with this same zeal that we have taken on Welfare Reform as a "serious matter." Through provisions of the Welfare Reform legislation, Mississippi has its first "serious" opportunity to offer welfare families, training and support crucial to increasing their potential to take care of their own.

Mississippi's JOBS program is now in its seventh month, operating in nine counties in the State. Seven additional counties are targeted for start-up this October. Services are being provided and/or arranged through a network of entities unlike any other in the Region and with similarities akin to only one or two other states in the country.

In Mississippi, eligibility for JOBS is determined by local MDHS Economic Assistance eligibility workers. Persons eligible for the program are then referred to a Community Action Agency (CAA) JOBS Case Management unit for assessment, employability planning and brokerage for services necessary to achieve their employment goals. Case managers assure the provision of certain supportive services such as transportation, and work with state procured Child Care Management Agencies (CCMA) to facilitate the arrangement of child care services. Using licensed social workers and supervisors, the Community Action Agency provides JOBS case management services to each client participating in the JOBS program.

In addition to tapping into resources available under the Community Action Agency umbrella, JOBS case managers rely on a network of resources provided by other community/local entities. A Memorandum of Understanding and other arrangements have been used as tools to facilitate the availability of various resources to participants. To date, we have established a Memorandum of Understanding with a total of eleven agencies and other entities at the state level. It is our absolute intent to prevent them from becoming meaningless pieces of paper.

"Coordination" is somewhat of a watch word for the program, thus, local coordinating councils (LCC) have been established for each JOBS/Community Action Agency service area to provide a vehicle for resource coordination and program ownership by the community. Some of the work of the LCC includes increasing client access to community resources, identifying community resource gaps and developing a plan for seeing that those gaps are filled, including those applicable to job creation. Approximately 202 citizens from both the private and public sectors are currently participating. At least 16 are JOBS/AFDC participants and 21 are from the business sector. We want to see those numbers increase; because, linkage between the group that needs employment and those having the potential for providing those opportunities will aid us in planning a more effective and meaningful program.

We clearly consider the use of Community Action Agencies to provide JOBS case management, and the establishment of Local Coordinating Councils, to be innovative. There are also other innovative program features which I would like to mention. We are utilizing the Department of Education to administer a Test of Applied Literacy Skills (TALS) which measures the participant's ability to perform quantitative operations and to read documents in the context of simulated, open-ended tasks. This is a deviation from typical assessments which measure literacy levels within the context of grade levels. VISTA program workers are being used to provide assistance to the case manager in accessing educational resources and providing emotional support and encouragement to the participant, through out the educational process. To facilitate the use of services offered through the Job Corps Program, we are scheduled to begin this month, a non-residential initiative with the Job Corps center located in central Mississippi. Other program strategies are being proposed to assure that we maximize the use of all available resources and allow for ongoing input in the planning process from those whom we serve.

While I am very enthusiastic about our JOBS program efforts, I do not want that enthusiasm to over shadow the many administrative and programmatic barriers which continue to exist. To begin my list of concerns, coordination is indeed an important element of the JOBS program; however, many services that AFDC clients utilize to sustain their families provide conflicting eligibility and program participation requirements which seem to defeat rather than promote the goal of assisting families to independence. As a simple example, the majority of families in Mississippi receiving AFDC benefits also receive Food Stamps. The two Federal agencies administering those services, both have employment training programs. However, there is only marginal evidence of any coordination regarding those programs occurring between the two agencies at the national level. While there seems to be great willingness on the part of both agencies to work with states on a case-by-case basis to assure coordination of the employment training programs at the state level, it would be extremely beneficial if policies and regulations for those programs could be made more compatible at the national level, before issuance to us. Again, this is only one example of the many conflicting regulations that we encounter as we work with families that use multiple resources.

Paperwork for the JOBS program, as is the case with the AFDC program, is monstrous. While there are many provisions that are available for developing a good program design, the paperwork and complexities associated with reporting requirements dissuade usage of the array of options available to states. Thus, the temptation becomes that of offering a marginal program that meets minimum federal requirements, but, is generally ineffective. Presently, we are required to capture information to a degree that not only consumes a tremendous amount of time on the part of eligibility workers for AFDC and case managers for JOBS, but, to the point that reporting expected of non-reimbursed service providers discourages enrollment of JOBS clients in their programs.

Adequate staffing is often referenced when there is discussion about the ability to render services effectively. This concern is not an exception for our JOBS program. Mississippi has on any given day approximately forty-nine to fifty thousand adult AFDC recipients. We anticipate that after exemptions, at least 60% of that number will be JOBS eligible. Since October 1, the JOBS case management units in the nine counties (comprised of eighteen case managers and eight supervisors) received nearly 2,500 referrals.

Currently, the average number of referrals per case manager is roughly 136, and climbing. To adequately provide case management services to the number of clients expected to participate in JOBS, the case manager/client ratio has to be more manageable. It has to be stabilized at a level that facilitates the client's timely progression to employability; otherwise, the stagnation inherent in inadequate staffing will be costly.

Supportive services will be essential to the success of working with parents through JOBS, especially for the teenage custodial parent. Understanding the significance of child care availability, Mississippi budgeted 47.6% of its JOBS and Supportive Services appropriation to child care. A problem still lies in our inability to use any portion of the federal funds for construction. The other piece of the supportive services puzzle that must be put into place through adequate program funding and continued coordination is transportation. The ruralness of this state and the lack of reliable private transportation among participants almost serves as the first nail in the coffin of a program which must get the people to the service. While some transportation is available through Urban Mass Transit program provisions, poor road conditions (many unpaved), cost of gasoline, vehicle maintenance and other costs (as weighed against insufficient payment for services rendered) deter potential providers from expanding their routes to serve JOBS clients. And, in view of the restriction on using funds to purchase vehicles for transporting JOBS clients, the potential for expansion of existing systems, or the establishment of some where non exist is neutered.

We are increasingly seeing individuals who obtained school loans (many through proprietary institutions) and have defaulted on them. This has nullified their ability to qualify for additional school loans and grants offered through the federal government. While they may have the potential for completing a post-secondary education to become more marketable and employable, the inability to get sufficient resources will significantly reduce the likelihood of doing so.

Job creation is of paramount importance to the success of our JOBS program efforts. We have people who come to the program with a variety of concerns and barriers; but, the one thing that they say to us in nearly every single situation is, "I want a job." We will have to have more than the general requirement of mandated coordination between JTPA and education to respond to that simple request. Improved linkage, nationally, between what is being taught and trained, and what is required for people to get jobs, is essential. This is especially critical, again, as it relates to prevention of long-term dependency among the teenage custodial parent.

In addition to improved linkage between training and employment options, we ask that you work to broaden policy to establish self-employment as a viable option for AFDC recipients. We encourage policy that would allow AFDC recipients to receive business training and seed-capital for business start-up, without being penalized by the loss of their benefits when that business loan is obtained and before the business has a reasonable chance to turn a profit. Further more, we suggest the establishment of lending policies and strategies that are based on the reality that poor people seldom have collateral. They also, seldom have credit records that are acceptable to traditional lending institutions. But when given a real opportunity, those that have the passion to do so can become entrepreneurs, like any other person in the general population. We have the evidence as you observed this morning and will hear in the testimony of the entrepreneur from the SEID program which recently received a 1991 JTPA Presidential Award.

While Child Support Enforcement provisions offered through Welfare Reform will aid in increasing the financial participation of non-custodial parents, lack of resources to recruit adequate staff will most likely hamper our custodial parents from reaping the full benefits of that provision. Also, we encourage Congress to consider the establishment of policies that would increase educational and training opportunities for the absent or non-custodial parents. This is of grave concern to us here in Mississippi, given the high rate of unemployment among that target group. To participate in supporting the child, income has to first be available to do so.

Two other points that I wish to touch on concern the need for policies and programs which address self-esteem building and asset building, and now we are beginning to attend to those issues. Often brought on by poverty, low self-esteem and feelings of lack of self-worth have for all practical purposes emotionally disabled a large segment of the poor population. We will venture to address this issue by piloting a project which focuses on building self-esteem and motivation through interpersonal skills development. Using mentors as one of the program's strategies, we expect to tap into resources offered through private sector involvement. In reference to asset building, we encourage Congress to consider legislation which would allow poor people to begin to obtain assets. To begin addressing this issue we are, in conjunction with federal and local entities, piloting an effort which makes funds available through a human investment strategy. The project is titled, SATURN, which is an acronym for Self-Advancement Through Unique Resource Networking.

Last, but, not least is a welfare reform initiative which derived from the concept of the "holistic" approach as a means for dealing with the multiple barriers of the family. Through this concept, low-income, single parents would be given the opportunity to reside in specialized communities as they prepare themselves for a transition into home ownership and self-sufficiency. Child Care, education, training, transportation and other services will be provided through a case management approach. Project sites are located in Vicksburg and Metcalfe. This project is a cooperative effort among agencies of the Executive Branch and others at the state and local level.

This concludes my testimony. I want to thank you, again for this opportunity to share these concerns, recommendations, and strategic options with you.

MALNUTRITION, CONSEQUENCES AND POSSIBLE SOLUTIONS

BY

AARON SHIRLEY, M.D.

As a participant in numerous hands on studies of poverty and hunger over the past 20 years in this country, the issue of malnutrition and education is of special interest to me. Before getting into specific implications of malnutrition and education I think it well to take a look at the extent to which poverty and hunger with resulting malnutrition exist.

There is really no precise way of knowing how many hungry people there are. But there are methods, fairly reliable I think, which can be used to estimate the dimensions of the problem and, based on these, there are probably 20,000,000 American who suffer from hunger. The majority of these, about 15 million, are people who live below the poverty line but who receive no food stamp assistance. The remainder are individuals and families who receive food stamps but for whom the program is inadequate and those who make up the near poor who are unable to make adequate food purchases for nutritionally adequate diets.

These figures in themselves are disturbing enough. But when we take into consideration the fact that hunger and malnutrition are directly related to poverty and 12.5 million American children live in poverty, and that 7.3 million of these are subjected to hunger on an ongoing basis, they take on added significance.

So what are the implications for education? Considerable evidence shows that maternal malnutrition during the prenatal period, or infant malnutrition during the early postnatal stage, can produce lasting damage to the structure and function of the developing nervous system of the baby. This damage is linked to long-term developmental deficits which manifest themselves by early childhood.

Cognitive Development: Brain structure itself is uniquely vulnerable to damage during the intrauterine period. Beginning shortly after conception, and extending until about the age of two years, the brain experiences maximal growth to about two-thirds of adult brain size. During this period the brain has biosynthetic abilities that do not extend into later life.

The absence of adequate nutrition during this critical period can produce permanent deficits in brain size--deficits which may not be reversible later even with ample nutrition. Survivors of severe childhood malnutrition show deficits in head circumference which reflect brain size. Malnutrition during this period is associated with identifiable structural deficits in the brains of children, including a decreased number of neurons and glial cells as measured by DNA content. Such deficits extend into adult life.

All children who suffer from growth retardation have at least one organically-based medical disease: malnutrition. Malnutrition can induce many biological changes, including decreased intracellular energy metabolism and altered cellular chemistry. Correlates of nutritional deficiency in young children include decreased velocity of peripheral nerve conduction, persistent temporal-parietal hypoplasia, and a slowing of EEG frequencies. Protein and amino acid chemistry is altered as the pool of available amino acids is depleted.

The malnourished condition leads to an alternation of the baseline metabolic state from one of anabolism (growth and increase in cell size, mass and tissue) to one of catabolism, or the autodigestion of tissue and muscle proteins. This is the body's way of trying to conserve energy for the most vital bodily function--organ preservation. These and related changes result in altered hormonal levels and organ activity, and become manifest in reduced physical activity, decreased exploration of the environment, and ultimately deficits in cognition itself.

Cognitive deficits associated with nutrition-based growth retardation range from moderate delays to mental retardation. The cumulative results of studies indicate that a high frequency (median of 50%) of children initially diagnosed as suffering growth retardation have significant intellectual deficits as older children. Moreover, most reports on preschool and school-aged children originally diagnosed as undernourished to the point of growth failure in infancy show high levels of chronic cognitive impairments compared to test norms.

The sponsors of this conference have asked that my presentation focus on three major themes, research, particularly, the identification of research needed to help at-risk children; policy, including policy recommendations for federal, state or local officials; and practice, encompassing innovative programs addressing the needs of at-risk children. From my own personal perspective this could best be done by presenting a summary of a seminar in which I was a participant which focused on services for disadvantaged youth.

From August 6-13, 1989 a group of 23 individuals met at the Aspen Institution for Humanistic Studies in Aspen, Colorado to examine and evaluate the concept of comprehensive social services to low income families and their impact on the educational achievement of young children in those families (through age 8). Our focus was on poor children in urban settings, a large proportion of whom are minorities.

The group included local and state officials concerned with the delivery of health, welfare, education and child development services; policy makers at all levels of government; and academics who had studied these issues. The seminar was part of a program supported by grants from the Carnegie, Ford, Hewlett, Rockefeller, and Primerica Foundations. Participants were asked to read approximately 100 pages of readings in preparation for the seminar, including journal and newspaper articles, program descriptions, and works in progress from several research centers.

The meeting was prompted by the growing sense among practitioners and scholars that the later educational performance of poor children is strongly affected by their health, nutrition, and home environment, especially in their earliest years. Studies suggest that improved and coordinated health, education, welfare, and child development services for poor families will pay substantial dividends in later educational achievement.

We hoped to address a number of questions raised by such findings, including:

- Are there successful examples of such combined services?
- What are the obstacles to providing such services?
- What role, if any, should the schools play in the delivery of services other than education?
- What might education policies, as well as health, welfare, and family policies, be altered to encourage--or at least not obstruct--efforts to provide comprehensive services?

What follows is a summary of several major assumptions, themes, unanswered questions, and other ideas that resulted from the group's deliberations.

Assumptions

During the week it became clear that participants began their discussions with a number of important assumptions about service delivery and the current political environment and respect to services for poor children and families. This section highlights several of these.

- Any improvement in services to poor children and families requires political will including federal and state commitment to the basic economic support of families.
- There are substantial improvements to be made in services to poor children and families using existing resources. More resources will ultimately be necessary, but those available are not yet fully utilized. More attention must be given to tapping private and corporate resources.
- High quality programs require competent, caring adults in direct contact with children and families.

Themes

Coordination:

A consistent refrain of the group's discussion was the need for increased coordination among service delivery agencies at both the departmental and line levels. The word "coordination" can be used to represent a variety of ideas in various circumstances. The meaning of the term that emerged from our discussion contains the following ideas:

The income, health, education, and other service needs of poor families are interconnected, and we believe that clients are most effectively served when their problems are addressed as a unit. Not only must a variety of services be available to children and families, but they should be easily accessible and available in combination. This might be achieved either through the co-location of service agencies in the community, or by establishing some sort of brokering/case management function through an existing or new agency. Such brokering should include:

- o Assessment of family (household) needs including the establishment of an improved data base.
- o Early problem resolution (with and without referral to other agencies).
- o Orchestration of specialized services and supports on behalf of the family including better access to the variety of services which already exist.

- Maintenance of an ongoing relationship with the family until problems are resolved or another agency has taken full responsibility.

These functions could be assumed through a number of possible organizational forms depending on state and local circumstances. This could be an existing agency taking a lead role, an interdisciplinary team or consortium, or a newly developed independent agency whose specific mission is to coordinate the delivery of services. Whatever its form, the organization must have the following qualities:

- Sensitivity to community values and dynamics.
- Good working relationships with service agencies and community resources.
- High quality staff who can successfully relate to families and specialized agencies.
- The trust of clients, agencies, and professionals in the community.

ACCOUNTABILITY

Our children represent the future of every community in the nation. Yet we allow far too many of them to grow up without the supportive environment they need. What is it we want for our children? In the broadest terms, we would wish that all young children, including those at risk, begin school healthy, curious, self-confident, and possessing the intellectual and social skills that will enable them to succeed academically, and, as they grow to adulthood, to succeed economically and as parents themselves. Recognizing the importance of the family to the child's development, we would also wish that the families of these young children are able -- or enabled -- to assure the child's well being, meeting his or her basic physical needs and to provide the care and nurturing that fosters positive emotional and intellectual growth.

How do we begin to achieve these broad goals? A substantial first step is for individual communities to establish a series of specific outcomes which will focus the community's energy and offer both immediate and long-term improvements in children's lives. These might include:

- A higher level of community awareness of the condition of its children and a higher level of community expectation for improving that condition.
- Fewer low birthweight babies.

- A lower rate of adolescent child bearing.
- A lower incidence of preventable illness among children.
- A higher level of cognitive and social functioning among young children both pre-school and in school.
- Fewer families depending on public assistance and more families earning an income adequate to meet their needs.

None of these are beyond the boundaries of our knowledge or resources. They are outcomes that are reasonable and achievable with interventions that are known to be effective. Moreover, they are measurable, allowing the community not only to make a public commitment to its children, but also providing the means to assure that that commitment is fulfilled.

We urge that service providers focus on the outcomes we want for our children. Goals such as these should be established for programs, and both individual agencies and the community as a whole must be held responsible for achieving them.

The measurement, monitoring, and acknowlegement of success of each agency's mission must be an ongoing process overseen by the community. Agencies must provide public standards of competency against which achievement and rates of progress can be measured. Objectives must be stated clearly in behavioral terms. Consequences of failure to achieve in a timely fashion must be made clear to those who deliver services. These strategies will, it is hoped, lead service deliverers to assume a more responsible posture. A consensus on objectives and ways to measure progress toward them is particularly critical because of the immense number and variety of workers involved in delivering services to children and families.

COMMUNITY EMPHASIS

Communities and states throughout the nation need to accept more responsibility for the conditions of their children. Such a commitment can be achieved through the direct involvement, mobilization, and empowerment of all who have a stake in the ultimate success of these children. Stakeholders include parents and families, educators, churches, public agencies, business and corporate leaders, private non-profit and for-profit day care providers, neighborhood and community organizations, and political leaders at all levels of government.

These groups will need to be mobilized by community leaders (mayor, private civic leaders, service agency heads, et al) to work together for the benefit of young children and the community's future.

In most cases, families are their own best case managers. They can be most effective in this role when the services they need are conveniently located, accessible and welcoming. Ideally, the services we are talking about -- prenatal care, hospital and home visiting, family support and child care -- would be locally based at single neighborhood sites, which might also be home to programs for young people and adults.

COMBINATION OF UNIVERSAL SCREENING AND TARGETTED SERVICES

Much of our discussion focused on the question of whether government services should be provided universally or targetted at specific needy populations. We settled on a combined model of universal screening with targetted services. Particularly appealing was the idea of home or hospital visits for each new mother by a social worker or other professional who could answer questions and offer advice about parenting. For those parents who need additional services, this individual could also act as a broker or liaison for the mother or family with other community agencies.

The period surrounding the birth of a child, particularly a first child, is a particularly critical opportunity at which to identify and aid families in need. For families found to be at risk, a complete assessment should include (but not be limited to) the following: income maintenance needs; health needs of the parents and child; educational or employement interests of the parents; and social needs of the parents and child. A second opportunity to identify such needs and to provide services is during the toddler/pre-school years when developmental child care services might be made available.

UNANSWERED QUESTIONS

While participants made progress on a number of issues regarding the delivery of services to children in poverty, there were several points at which the group felt overwhelmed by an obvious need, but unsure what steps might be most helpful. The most significant of these are explained briefly below.

The discussion of programs for poor youngsters today generally focuses on "children at risk" and what interventions might be effective to improve their prospects for the future. During our deliberations, however, it quickly became clear that there are in fact at least two groups of youngsters towards which policies must be directed, and that the two have quite distinct needs. The first group, toward whose benefit the themes above are addressed, are those children who we suspect, according to whatever criteria we choose, are "at risk" of some future problem which we seek to avoid through present interventions. The second group is that smaller subset of children who have already been placed in severe trouble by their environment and family situations. Some are victims of direct abuse or neglect, while others live in such chaos because of drugs or other factors that their needs are immediate, urgent, and unavoidable. These children with severe problems and urgent needs were not the focus of the bulk of the discussion. We only note that existing child protective services are clearly inadequate to meet their needs and that special, intensive (and likely costly) solutions will need to be devised.

A second set of issues the group was not able to focus on at this time but felt needed additional thought was the question of institutional capacity and the information systems needed to support more effective service delivery in the long run. We believe the ideas discussed above will lead to marked improvement in the delivery of services to many and perhaps even the majority of poor children. But until institutional mores change, job descriptions are expanded, and accountability and rewards are altered, shifts in policy may not be felt sufficiently at the service delivery level. More analysis and discussion will be necessary to address these issues adequately.

Finally, changes of the sort we have proposed will require a public commitment to solving the problems of poverty in our society. Generating sufficient political will for such an effort, including individual and private group contributions as well as those of public agencies, is a daunting task and a challenge we felt unprepared to meet directly. While each of us will continue to strive as best we can to meet the needs of these children, we cannot make more than incremental progress until we as communities and as a society decide that all our children are a vital resource which we cannot afford to abandon.

OTHER IDEAS

In addition to those assumptions, themes, and unanswered questions discussed above, a number of other ideas arose during the course of discussion on which consensus was either not sought or was not apparent. This section mentions several of these.

Many participants felt strongly that groups similar to the Aspen seminar, convened to bring together a variety of individuals from the same community rather than a national group, could be invaluable in better meeting the needs of children in that community. A separate document has been developed in an attempt to outline what would be necessary to convene such a group: who might participate, what topics might be discussed, and what possible outcomes might be achieved.

There are several reasons a community or state might want to nvene a diverse group to discuss services for poor children. Such discussions could be useful in mobilizing community support on behalf of poor children and their families, in fostering understanding and commitment across individuals, agencies, and organizations who serve the disadvantaged, and in beginning to create a community sense of responsibility, accountability, and self interest in addressing the problems of at risk children.

Several participants were intrigued by the idea of establishing a new, ungraded educational unit to replace what is now separate as kindergarten and grades one, two and three. Such an ungraded school environment would allow children to learn at their own pace and staff would be deployed in more collaborative ways to help children to succeed.

Additional discussion and clarification may be helpful on several related topics. These include finding ways to conduct and disseminate more coordinated research across disciplinary lines; developing ideas regarding how to expand staff capacity and more appropriately define the professional roles of service deliverers; and creating a better understanding of what might be involved in taking a broad view of clients' needs.

SUBMISSIONS TO THE HOUSE SELECT COMMITTEE ON HUNGER
BOLTON, MISSISSIPPI
MAY 3, 1991

SUBMITTED BY:
PARTNERS FOR IMPROVED NUTRITION AND HEALTH
P. O. BOX 531, GREENWOOD, MISSISSIPPI, 38930
(601) 453-1886 / 453 - 1975

1. Oral Testimony of Ms. Viola Hudson,
MCES EFNEP Educator
Partners for Life Project
Hollandale, Mississippi.

Written Testimony submitted "for the record":

2. "Partners for Improved Nutrition and Health (PINAH): Self-help, Partnerships, Outreach and Access" (Program overview presented to the North Carolina Healthy Generations Project, Raleigh, North Carolina, September, 1990).

3. "PINAH Evaluation Progress Report: 1988 - 1989". Eugenia Eng, DrPH, University of North Carolina, November, 1989.

4. "Partners for Life: Interagency Collaboration to Provide Perinatal Nutrition and Health Education." (Case Study presented to the Association of Southern Agricultural Workers, Tuskeegee, Alabama, December, 1990).

5. Community Health Workers in Rural Mississippi - Mobilizing Natural Helping Networks. (Case Study presented to the American Public Health Association, New York, October, 1990)

SELF-EMPLOYMENT INITIATIVE DEMONSTRATION PROJECT CANTON, MISSISSIPPI

Mississippi's Self-Employment Initiative Demonstration (SEID) began operation in October 1988. It is part of a four-State national demonstration project developed by the Corporation for Enterprise Development established with the purpose of providing low-income persons the opportunity and support network for setting up small businesses. The program is sponsored by the Friends-of-Children of Mississippi, the Mississippi Department of Human Services, the local government and businesses, the Levi Strauss Foundation, the Mott Foundation and the Gannett Foundation. Funds under Title II-A of the Job Training Partnership Act are used for training and for collateral of the business loans.

During the period 1989-1990, there were twenty-three persons enrolled in the program -- twenty-two females and one male.
Of this group:

- 87 percent were single parents with dependents under 18 years of age;
- 91 percent were minorities;
- 43 percent had reading levels below the 7th grade;
- 100 percent participated in the Food Stamp Program
- 52 percent were considered long-term AFDC recipients;
- 91 percent received public assistance; and
- 100 percent were considered to be economically disadvantaged

Outstanding Training Program

Self-Employment Initiative Demonstration Program

Jackson, Mississippi

The Mississippi Service Delivery Area Private Industry Council, guided by the Corporation for Enterprise Development, funded this non-traditional JTPA program designed to move the poorest of the poor to self-sufficiency and place them in the mainstream of the economic system through micro-business ownership.

The program is part of a multi-agency, multi-year national demonstration in which the Department of Health and Human Services granted 12-month waivers, allowing new business owners to secure capital and "grow their business" without loss of welfare benefits.

This program benefits from the collaborative efforts of the public and private sectors, including the Friends-of-Children of Mississippi, the Mississippi Department of Human Services, the local government and businesses, the Levi Strauss Foundation, the Mott Foundation and the Gannett Foundation. The JTPA Title II-A funds provided training and several foundations contributed funds to be used as collateral for the new business loans. Area professionals served as mentors and businesses provided technical assistance to the participants.

Specific training and assistance were provided to 23 economically disadvantaged, predominantly single, female heads-of-household, who had less than 7th grade reading levels and received public assistance. The 18-month participant program included self-concept building, motivation, personal finance, researching and writing business plans, completing market surveys, profit/loss and cash flow projections, basic accounting and money management.

After completing 160 hours of training, participants received individual assistance to help secure business loans and start-up. Once the business was started, the program provided on-site consultation and negotiated support services to alleviate transportation and child care barriers.

The program's accomplishments resulted in perceptual changes in two diverse communities—public assistance recipients and the private business community. Since 8 viable businesses have been created or planned by 17 program participants who completed training, the program has demonstrated that micro-business creation is an alternative job creation source, especially in a rural market where unemployment exceeds the national rate.

Carolyn Moore, Graduate

Carolyn used to feel that she would be on welfare forever. Now she owns and operates a janitorial service that grosses approximately $1400 per month. She was participant in the SEID.

During the initial training phase of the program, Carolyn talked about the degradation she felt by being on welfare. She recalled a situation when she was in line at a supermarket purchasing groceries with her sons. As she was paying for her groceries with her food stamps, a man at the back of the line shouted out, "Shouldn't they be in another line? We're paying cash."

Carolyn started her business in October 1989 and is receiving reduced AFDC benefits. She expects to be able to leave welfare with a few more contracts. Carolyn is a single mother with three sons. Her children are very proud of her and assist her in the business. She feels very good about herself and hopes that she can be a role model for other women on welfare.

HOME VISIT - MS. PEARLENE SMITH
CANTON, MS

Ms. Smith is 55 years of age. She-and her family have been living in the home we will visit for 15 years. There are currently 12 family members -- ranging in age from 28 years to one year -- residing in the home.

The family receives $700 per month in food stamp benefits and $456 per month in AFDC benefits (for seven children and three adults). The family had been paying $20 per month for rent; however, the landlord recently stopped charging them. The have just receive a Section-8 housing certificate and will soon be moving into a four-room trailer.

HOME VISIT - MS. LILLIAN WASHINGTON
FLORA, MS

Ms. Washington is 63 years old and disabled. She and her four children (aged 22,22,24 and 30) and seven grandchildren (aged 6,5,4,3,2,1, and 2 months) reside in a trailer.

The family currently receives $120 per month in AFDC payments and $358 per month in food stamp benefits. Ms. Washington receives $407 per month in disability and one of her sons receives $407 per month in disability payments.

LUNCH - SENIOR NUTRITION CENTER
BOLTON, MS

The nutrition site at Bolton houses both the congregate program operated by the Town of Bolton Development Corporation and the home-delivered program operated by Hinds County Human Resource Agency. Approximately 20 individuals receive congregate meals and 42 individuals are served through the home-delivered program. The site has been in operation for 15 years.